89-994

No. _____

Supreme Court, U.S.
FILED
DEC 22 1989
JOSEPH F. SPANIOL, JR.
CLERK

IN THE

Supreme Court of the United States

October Term, 1989

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.,

Petitioner,

v.

ROBERT CASEY, Governor of the Commonwealth of Pennsylvania, JOHN F. WHITE, Secretary of the Pennsylvania Department of Public Welfare, and DAVID S. FEINBERG, Director of the Bureau of Policy and Program Development of the Pennsylvania Department of Public Welfare,

Respondents,

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Robert T. Adams
McGUIRE, WOODS, BATTLE & BOOTHE
One James Center
Richmond, Virginia 23219
(804) 775-1000

Counsel of Record

December 22, 1989

Additional Counsel
Listed Inside Cover

Appellate Printing Services • Heritage Building • Suite 908 • Richmond, VA 23219 • (800) 642-7789

Julia Krebs-Markrich
McGUIRE, WOODS, BATTLE & BOOTHE
The Army and Navy Club Building
1627 Eye Street, N.W.
Washington, D.C. 20006
(202) 857-1700

Jack M. Stover
METTE, EVANS & WOODSIDE
1801 North Front Street
Harrisburg, Pennsylvania 17102
(717) 232-5000

Counsel for Petitioner

QUESTION PRESENTED

May an award of attorneys' fees under 42 U.S.C. § 1988 include compensation for expert witnesses?

RULE 28.1 LISTING

West Virginia University Hospitals, Inc., is a public corporation created by the West Virginia Legislature. See § 18-11c-2(d) of the Code of West Virginia. It has the following subsidiary (not wholly owned) and affiliate:

Subsidiary: HealthNet Insurance Company

Affiliate: Health, Education and Research Corporation

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
RULE 28.1 LISTING	ii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTE INVOLVED	2
STATEMENT OF THE CASE	3
REASONS FOR GRANTING THE WRIT OF CERTIORARI	6
An Award Under 42 U.S.C. § 1988 May Include Expert Witness Fees	6
CONCLUSION	10
APPENDIX	
A. Opinion Sought To Be Reviewed	A-1
B. Published Opinion Of The District Court	B-1
C. Unpublished Opinion Of The District Court	C-1

TABLE OF AUTHORITIES

CASES

	Page
Alyeska Pipeline Service Co. v. Wilderness Society, 421 U.S. 240 (1975)	8,9
Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437 (1987)	8,9
Denny v. Westfield State College, 880 F.2d 1465 (1st Cir. 1989)	6,8,9
Friedrich v. City of Chicago, 888 F.2d 511 (7th Cir. 1989)	6,7, 8,9
Missouri v. Jenkins, ___ U.S. ___, 109 S. Ct. 2463, 105 L. Ed. 2d 229 (1989)	6,7, 8,9
Ramos v. Lamm, 713 F.2d 546 (10th Cir. 1983)	6
SapaNajin v. Gunter, 857 F.2d 463 (8th Cir. 1988)	6
Sevigny v. Dicksey, 846 F.2d 953 (4th Cir. 1988)	6
United States v. Ron Pair Enterprise, Inc., ___ U.S. ___, 109 S. Ct. 1026, 103 L.Ed.2d 290 (1989)	7
West Virginia University Hospitals, Inc. v. Casey, 701 F. Supp. 496 (M.D. Pa. 1988)	2,3, 4,5
West Virginia University Hospitals, Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989)	2,5, 6,8

STATUTES

28 U.S.C. § 1254(1)	2
28 U.S.C. § 1331	4
28 U.S.C. § 1332	4
28 U.S.C. § 1343(3)	4
28 U.S.C. § 1343(4)	4
28 U.S.C. § 1821	9
28 U.S.C. § 2201	4
42 U.S.C. § 1396a(a)(13)(A)	4
42 U.S.C. § 1396a(a)(37)	4
42 U.S.C. § 1983	4
42 U.S.C. § 1988	2,5,6, 7,8,9

MISCELLANEOUS

Rule 17, Rules of the United States Supreme Court	10

No. ___

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1989

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.,

Petitioner,

v.

ROBERT CASEY, Governor of the Commonwealth of Pennsylvania, JOHN F. WHITE, Secretary of the Pennsylvania Department of Public Welfare, and DAVID S. FEINBERG, Director of the Bureau of Policy and Program Development of the Pennsylvania Department of Public Welfare,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

The petitioner, West Virginia University Hospitals, Inc., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Third Circuit, entered in the above-entitled proceeding on September 5, 1989.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Third Circuit is reported at 885 F.2d 11, and is included in the Appendix at A-1 to A-49. The opinion of the United States District Court for the Middle District of Pennsylvania is reported at 701 F. Supp. 496, and is included in the Appendix at B-1 to B-68. An unpublished memorandum opinion of the District Court concerning an award of attorneys' fees is included in the Appendix at C-1 to C-4.

JURISDICTION

The decision of the United States Court of Appeals for the Third Circuit was issued on September 5, 1989. An order, denying petitioner's timely request for a rehearing, was issued by the United States Court of Appeals for the Third Circuit on October 5, 1989. The mandate of the United States Court of Appeals for the Third Circuit was issued on October 13, 1989.

The jurisdiction of this Court to issue a writ of certiorari in this case is based upon 28 U.S.C. § 1254(1).

STATUTE INVOLVED

42 U.S.C. § 1988.
Proceedings in vindication of civil rights; attorney's fees

> *The jurisdiction in civil and criminal matters conferred on the district courts by the provisions of this Title, and of Title "**CIVIL RIGHTS**," and of Title "**CRIMES**," for the protection of all persons in the United States in their civil rights, and for their vindication, shall be exercised and enforced in conformity with the laws of the United States, so far as such laws are suitable to carry the same into effect; but in all cases where they are not adapted to the object, or are deficient in the provisions necessary to furnish suitable remedies and punish offenses against law, the common law, as modified and changed by the constitution and statutes of the State wherein the court having jurisdiction of such civil or criminal cause is held, so far as the same is not inconsistent with the Constitution and laws of the United States, shall be extended to and govern the said courts in the trial and disposition of the cause, and, if it is of a criminal nature, in the infliction of punishment on the party found guilty. In any action or proceeding to enforce a provision of sections 1981, 1982, 1983, 1985, and 1986 of this title, title IX of Public Law 92-318, or title VI of the Civil Rights Act of 1964, the court, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee as part of the costs.*

STATEMENT OF THE CASE

West Virginia University Hospitals, Inc., (hereinafter referred to as "WVUH") operates a tertiary medical center in Morgantown, West Virginia, six miles south of the border between the Commonwealth of Pennsylvania and the State of West Virginia. 701 F. Supp. at 498-499 (Findings of Fact # 7, 14, and 15); Appendix at B-3 to B-4. As a consequence, WVUH is a significant provider of hospital services to Pennsylvania medicaid recipients living in southwestern Pennsylvania. 701 F. Supp. at 498-499 (Findings of Fact # 8-22); Appendix at B-3 to B-5.

In January, 1986, Pennsylvania's Department of Public Welfare notified WVUH of new medicaid payment rates for WVUH's hospital services to Pennsylvania medicaid recipients. Convinced that the new payment rates were contrary to the minimum standards for reimbursement specified in the Social Security Act, WVUH attempted to resolve the problem administratively. However, the Pennsylvania Department of Public Welfare informed WVUH that an administrative appeal,

based upon the methodological inadequacies of Pennsylvania's reimbursement system, would not lead to any relief. See 701 F. Supp. at 521; Appendix at B-56.

Consequently, in July, 1986, WVUH filed suit in the United States District Court for the Middle District of Pennsylvania. WVUH challenged the adequacy of Pennsylvania's payment system and the adequacy of Pennsylvania's medicaid administrative appeals system under federal law.[1] The jurisdiction of the district court was based upon 28 U.S.C. § 1331, 28 U.S.C. § 1343(3) and (4), and 28 U.S.C. § 1332. WVUH also sought remedies under 42 U.S.C. § 1983 and under 28 U.S.C. § 2201.

In May and June, 1988, the District Court conducted a six-day trial. At trial, WVUH depended upon the testimony of three expert witnesses who testified about the deficiencies in Pennsylvania's payment system for out-of-state hospitals like WVUH and the inadequacy of Pennsylvania's administrative appeals system. These experts were essential both at trial and during the pretrial preparation of the case between 1986 and 1988.

1 WVUH alleged four causes of action in its complaint:
(1) the inadequacy of the payment system under 42 U.S.C. § 1396a(a)(13)(A);
(2)the lack of any basis-in-fact for the assurances Pennsylvania officials provided the Federal Government about the payment system as required by 42 U.S.C. § 1396a(a)(13)(A);
(3)the inadequacy of the administrative appeals system under 42 U.S.C. § 1396a(a)(37) and the implementing federal regulations; and
(4) a violation of the Equal Protection Clause of the United States Constitution due to the irrational discrimination in payments made by Pennsylvania's medicaid program to out-of-state hospitals as contrasted to payments made in-state hospitals.

The District Court declared that Pennsylvania's payment system and her administrative appeals system violated federal law. 701 F. Supp. at 526; Appendix at B-67. The District Court ordered the Pennsylvania defendants to develop new payment and appeals systems by May 1, 1989. The District Court also awarded fees under 42 U.S.C. § 1988 after submission of a joint fee proposal by the parties.

In making the fee award, the District Court included expert witness fees, having concluded that the experts' work was "essential" to the District Court's decision. Appendix at C-2. Moreover, in the joint fee proposal submitted by WVUH and the Pennsylvania defendants, the parties stipulated that the experts' work, which encompassed both pretrial and trial work, was "necessary" and that $104,133.00 was a reasonable amount of compensation for such work. See Appendix at C-1 to C-2.

The Court of Appeals for the Third Circuit ultimately affirmed the District Court in all but two respects. First, the Court of Appeals held that expert witness fees were not compensable in an award of attorneys' fees under 42 U.S.C. 1988. 885 F.2d at 35; Appendix at A-48. This ruling is in direct conflict with rulings of the Seventh, Eighth, and Tenth Circuits. Secondly, the Court of Appeals reversed the District Court on the issue of the adequacy of Pennsylvania's administrative appeals system.

The Court of Appeals refused to rehear the case as requested by WVUH. Consequently, WVUH has petitioned this Court for a writ of certiorari.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

An Award Under 42 U.S.C. § 1988 May Include Expert Witness Fees.

The Third Circuit's ruling upon the compensability of expert witness fees under 42 U.S.C. § 1988 is a part of a multi-circuit conflict. The Fourth Circuit, the First Circuit, and now the Third Circuit hold that expert witness fees are not compensable under 42 U.S.C. § 1988.[2] See Sevigny v. Dicksey, 846 F.2d 953 (4th Cir. 1988); Denny v. Westfield State College, 880 F.2d 1465 (1st Cir. 1989); West Virginia University Hospitals, Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989) (Appendix at A-1 to A-49). By contrast, the Eighth Circuit, Tenth Circuit, and, most recently, the Seventh Circuit, have held that an award under 42 U.S.C. § 1988 may include expert witness fees. See SapaNajin v. Gunter, 857 F.2d 463 (8th Cir. 1988); Ramos v. Lamm, 713 F.2d 546 (10th Cir. 1983); Friedrich v. City of Chicago, 888 F.2d 511 (7th Cir. 1989).

This conflict between the Courts of Appeals on this issue is an important one which is best illustrated by the difference in approach taken by the Third Circuit and by the Seventh Circuit in their recent decisions. These decisions sharply contrast one another in their respective applications of this Court's decision in Missouri v. Jenkins, ___ U.S. ___, 109 S. Ct. 2463, 105 L.Ed.2d 229 (1989).

Missouri v. Jenkins clearly establishes that an award of attorneys' fees under 42 U.S.C. § 1988 is not limited to fees

---

2 The First Circuit's holding in this regard extends only to testimonial work in court; the First Circuit has not yet decided whether nontestimonial work is compensable under 42 U.S.C. § 1988. See 880 F.2d at 1472.

generated by attorneys. Instead, this Court has ascertained that the Congressional intent behind 42 U.S.C. § 1988 is to provide a "'fully compensatory fee.'" See Missouri v. Jenkins, 109 S. Ct. at 2471, 105 L.Ed.2d at 242. In light of that intent, this Court has explained that fee awards may take into account the work of non-attorneys "whose labor contributes to the work product for which the attorney bills her client." 109 S. Ct. at 2470, 105 L.Ed.2d at 241.

Speaking for the Seventh Circuit in Friedrich v. City of Chicago, Judge Posner provides a thoughtful analysis of 42 U.S.C. § 1988 and of Missouri v. Jenkins, in which he specifically rejects the Third Circuit's conclusion reached in this case. First, Judge Posner points out that this Court has flatly rejected the argument that the plain language of 42 U.S.C. § 1988 contemplates a fee award for only an attorney's fees, not an expert's fee. 888 F.2d at 513. Following this Court's example in Missouri v. Jenkins, Judge Posner applies the paramount rule of statutory construction that the intention of the drafters of the legislation prevails over the strict language of the statute. Id. at 514 (citing United States v. Ron Pair Enterprise, Inc., ___ U.S. ___, 109 S. Ct. 1026, 103 L.Ed.2d 290 (1989)). Judge Posner succinctly states:

> *When a court can figure out what Congress probably was driving at and how its goal can be achieved, it is not usurpation -- it is interpretation in a sense that has been orthodox since Aristotle -- for the court to complete (not enlarge) the statute by reading it to bring about the end that the legislators would have specified had they thought about it more clearly or used a more perspicuous form of words. That is what the Supreme Court did in the Jenkins case.*

888 F.2d at 514.

In his analysis, Judge Posner recites the history of the enactment of 42 U.S.C. § 1988, beginning with this Court's

holding in Alyeska Pipeline Service Co. v. Wilderness Society, 421 U.S. 240 (1975). That history clearly reveals Congress' intention to overrule Alyeska by the enactment of 42 U.S.C. § 1988 to provide for a fully compensatory fee -- a fact noted by this Court in Missouri v. Jenkins when addressing the issue of whether paralegal fees were compensable under 42 U.S.C. § 1988. 109 S. Ct. at 2470-2471, 105 L.Ed.2d at 241-242; see also Friedrich v. City of Chicago, 888 F.2d at 514.

Just as paralegals assist in the preparation of an attorney's work product, experts educate counsel and preclude the need for the attorney to educate himself, which would obviously require more time and run up an attorney's fees even more. 888 F.2d at 514. Judge Posner wisely warns that a refusal to pay experts' fees would encourage underspecialization and inefficient trial preparation "just as to forbid shifting the cost of paralegals would encourage lawyers to do paralegals' work." Id.

While the Third Circuit attempts to distinguish Missouri v. Jenkins, see 885 F.2d at 34; Appendix A-47, Judge Posner persuasively and cogently rejects the possibility that Missouri v. Jenkins is distinguishable. 888 F.2d at 514. The Third Circuit holds that, because witness fees are governed by 28 U.S.C. 1821, the controlling precedent is Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437 (1987), rather than Missouri v. Jenkins. 885 F.2d at 34; App. A-47. What the Third Circuit ignores, but Judge Posner does not, is the fact that Crawford did not involve 42 U.S.C. § 1988. 888 F.2d at 515. Indeed, 28 U.S.C. § 1821 is specifically inapplicable where another statute, like 42 U.S.C. § 1988, provides for costs or fees. 888 F.2d at 515.

Even if 28 U.S.C. § 1821 were applicable, Judge Posner observes that that statute deals only with testimonial work performed by experts; it does not affect nontestimonial work by experts. Therefore, expert fees for non-testimonial work are not controlled in any way by Crawford. Id.; see also Denny v.

Westfield State College, 880 F.2d at 1472 (in which the First Circuit also notes the distinction).

Judge Posner also rejects arguments, based upon Crawford, to the effect that courts should not lightly infer a repeal of 28 U.S.C. § 1821 by provisions of law that do not explicitly refer to witness fees. 888 F.2d at 515. Again, Judge Posner points out that it is Congressional intent that controls and that, based on that intent, witness fee awards under 42 U.S.C. § 1988 are excluded from 28 U.S.C. § 1821. Id. at 516.

The Congressional intent to exclude expert witness fees from the reach of 28 U.S.C. § 1821 is apparent from the history of 42 U.S.C. § 1988. Prior to this Court's decision in Alyeska, the federal courts awarded expert witness fees under what they believed to be their general equitable powers. In Alyeska, this Court held that the equitable powers of the federal courts were not so broad. Congress reacted to Alyeska by enacting 42 U.S.C. § 1988 to grant such equitable powers. Judge Posner in Friedrich provides a telling discussion of the status of pre-Alyeska law and the evidence of the Congressional intent to return to the status of pre-Alyeska law, which authorized reimbursement of expert witness fees. 888 F.2d at 517-518. His conclusion that expert witness fees are compensable under 42 U.S.C. § 1988 is compelled by the history of that statute's enactment and this Court's decision in Missouri v. Jenkins.

This Court has long heeded the rule of giving effect to legislative intent and has required the lower courts to honor that rule. The Third Circuit has failed to do so. This Court's decision in Missouri v. Jenkins rejected the facile argument, now adopted by the Third Circuit in this case, that the words "attorney's fees" in 42 U.S.C. § 1988 mean only fees generated by attorneys. Having decided in Missouri v. Jenkins that paralegal work is compensable under 42 U.S.C. § 1988, this Court ought now to address the parallel issue raised by the Third Circuit's erroneous decision in

this case. By doing so, this Court will resolve the continuing and growing conflict between the Courts of Appeals.

CONCLUSION

For these reasons, this petition for a writ of certiorari should be granted. The question presented fully satisfies the criteria set forth in Rule 17 of the Rules of the Supreme Court.

Therefore, WVUH requests that a writ of certiorari issue to review the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted,

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.

By /s/ Robert T. Adams
Counsel of Record

Robert T. Adams
McGUIRE, WOODS, BATTLE & BOOTHE
One James Center
Richmond, Virginia 23219
(804) 775-1000

Counsel of Record

Julia Krebs-Markrich
McGUIRE, WOODS, BATTLE & BOOTHE
The Army and Navy Club Building
1627 Eye Street, N.W.
Washington, D.C. 20006
(202) 857-1700

Jack M. Stover
METTE, EVANS & WOODSIDE
1801 North Front Street
Harrisburg, Pennsylvania 17102
(717) 232-5000

Counsel for Petitioner

December 22, 1989

APPENDIX A

FILED: SEPTEMBER 5, 1989

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NO. 89-5165

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.

v.

ROBERT CASEY, Governor, Commonwealth of Pennsylvania; **JOHN WHITE,** Secretary, Department of Public Welfare; **DAVID S. FEINBERG,** Director, Office of Medical Assistance; **THE DEPARTMENT OF PUBLIC WELFARE,**

Appellants

Appeal from the United States District Court
for the Middle District of Pennsylvania
D.C. Docket No. Civil 86-0955

Argued May 22, 1989
Before BECKER, STAPLETON, and ROSENN,

Circuit Judges
Opinion Filed September 5, 1989

ERNEST D. PREATE, JR., Attorney General
JEROME T. FOERSTER, Deputy Attorney General (Argued)
CALVIN R. KOONS, Senior Deputy Attorney General
JOHN G. KNORR, III, Deputy Attorney General

Chief, Litigation Section
Office of Attorney General
Litigation Section
15th Floor, Strawberry Square
Harrisburg, PA 17120

Attorneys for Appellants

ROBERT T. ADAMS, ESQ.
(Argued)
JULIA KREBS-MARKRICH, ESQ.
THOMAS J. STALLINGS, ESQ.
McGuire, Woods, Battle & Boothe
One James Center
Richmond, Virginia 23219

JACK M. STOVER, ESQ.
Shearer, Mette, Evans & Woodside
1801 North Front Street
P.O. Box 729
Harrisburg, PA 17108-0729

Attorneys for Appellees

OPINION OF THE COURT

ROSENN, J., Circuit Judge

This interesting and complex appeal arises from the cross-fire currently trapping many hospitals across our nation between rising operating costs, on the one hand, and federal legislation aimed at the sharp containment of health delivery costs, on the other. The plaintiff, West Virginia University Hospitals, Inc. (WVUH or the Hospital), brought this action against certain Pennsylvania state officials under the Civil Rights Act, 42 U.S.C. § 1983, alleging that the Pennsylvania program for providing medicaid reimbursement to an out-of-state hospital such as WVUH violated federal medicaid standards encompassed by Title XIX of the federal Social Security Act and violated the equal protection clause of the fourteenth amendment to the United States Constitution. WVUH also claimed that Pennsylvania's administrative appeals system was legally inadequate. The Hospital sought injunctive and declaratory relief invalidating the out-of-state aspects of the State's hospital reimbursement program.

After a bench trial before the United States District Court for the Middle District of Pennsylvania, the district court, in a thoughtful and painstaking opinion published at 701 F. Supp. 496 (M.D. Pa. 1988), granted WVUH's request for relief on all counts. District Judge Rambo concluded that Pennsylvania's reimbursement program as applied to WVUH violated both federal statutory law and the equal protection clause of the Constitution, and held that the state's administrative appeal system was legally inadequate. She ordered Pennsylvania to revise its reimbursement methodology for WVUH and to formulate an adequate and meaningful medicaid administrative appeals system for the Hospital. Additionally, the court held that the State must permit WVUH to avail itself of the new appeals system to challenge its reimbursements from the date the Hospital commenced this action, rather than from the date of

judgment. Finally, in an unpublished memorandum and order also issued the day of judgment, the district court awarded attorneys fees to the plaintiff pursuant to 42 U.S.C. § 1988 in the amount of $500,000, of which $104,133 was attributable to expert witness fees and costs.

Pennsylvania appeals, challenging the decision on the merits, the scope of relief, and the award of expert witness fees. We affirm in part and reverse in part.

I. FACTS

A. The Parties.

The plaintiff WVUH is a university-affiliated teaching hospital located six miles south of the border between West Virginia and Pennsylvania. As a "tertiary care" hospital, WVUH provides a complex level of hospital and medical services not generally found in community hospitals. WVUH is the closest source of tertiary care for many residents in the Pennsylvania counties of Fayette and Greene, and provides services as well to residents of the Pennsylvania county of Washington. Historically, the Hospital has provided significant numbers of Pennsylvania medicaid patients with hospital care. For the years 1984 to 1987, WVUH gave inpatient hospital care to more Pennsylvania medicaid patients than did over one-half of the hospitals located in Pennsylvania. Five percent of all WVUH inpatient admissions are attributable to Pennsylvania medicaid recipients, while overall medicaid patients at WVUH constitute twenty-three percent of all admissions. WVUH is by far the largest out-of-state provider of medical services to Pennsylvania medicaid recipients.

The defendants in this action are Pennsylvania Governor Robert Casey, John F. White, the Secretary of Pennsylvania's Department of Public Welfare (DPW), and David Feinberg, the DPW official responsible for developing the Pennsylvania

hospital reimbursement program at issue in this case. Although technically incorrect, for simplicity's sake this opinion may occasionally use the words "Pennsylvania" or "the State" when referring to the defendants.

B. The federal medicaid act.

In 1965 Congress enacted Title XIX of the Social Security Act (known as Medicaid or The Medicaid Act) to provide medical assistance to needy persons. 42 U.S.C. § 1396 et seq. The purpose of the act was to provide a nationwide program of medical assistance for low income families and individuals. Medicaid became the primary source of health care coverage for the poor in America. The program is jointly financed with federal and state funds "and is basically administered by each state within certain broad requirements and guidelines." House Subcomm. on Health and the Environment, Data on the Medicaid Program: Eligibility, Services, Expenditures Fiscal Years 1967-77, H.R. Rep. No. 10, 95th Cong., 1st Sess. 1. The federal unit currently responsible for overseeing the medicaid program is the Health Care Financing Administration (HCFA). Federal law requires that one state agency must be designated as the single state agency responsible for the administration of the program. The state determines the scope of the services offered and generally determines the eligibility level for the programs. Id. at 1-2. Thus, the Act implemented a federal-state joint venture in which participating states receive federal medicaid funds in return for administering a medicaid program developed by the state within the parameters established by federal law and regulations.

Before 1980, Title XIX require states to pay hospitals the "reasonable cost" of rendering inpatient hospital services to medicaid recipients. This requirement translated into a retrospective form of reimbursement based on the actual costs incurred by the hospitals in providing medicaid services. In 1981, however, Congress, hoping to contain escalating medicaid costs, enacted as part of the 1981 Omnibus Budget Reconciliation Act

(OBRA), P.L. 97-35, a new standard of hospital reimbursement. The OBRA replaced the "reasonable cost" standard with the current standard of "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C.A. § 1396(a)(13)(A) (West Supp. 1989).

The 1981 OBRA also reduced federal oversight of states' reimbursement methodologies. Pursuant to section 1396a(a)(13)(A), the HCFA will approve a state reimbursement plan based on the state's satisfactory "assurances" that the plan is in compliance with federal requirements. These requirements are reflected both in the statute itself and in its implementing regulations published by the HCFA in interim form in 1981 and in final form in 1983. 42 C.F.R. §§ 447.250-447.280.

C. The Pennsylvania medicaid program: operating cost, direct medical education cost, and capital cost reimbursement.

In Pennsylvania, DPW is the state agency responsible for administering medicaid. The medicaid program developed by DPW for the state is called the "Medicaid Assistance Program" or "MAP."

Consistent with the 1981 federal policy change with respect to hospital reimbursement, Pennsylvania developed a "prospective payment system" (PPS) for reimbursement of hospitals to contain escalating costs associated with medicaid services. This system, effective beginning fiscal year 1984-1985, replaced the retrospective method of reimbursement with a prospective method. Under this system, each hospital admission is classified according to the patient's illness diagnosis into 1 of 477 categories known as Diagnostic Related Groups (DRGs). 53 Fed. Reg. 38,576-89 (1988). A hospital is reimbursed in accordance with the flat fee fixed for the applicable category -- regardless of the number of services used or the patient's length of stay. The DRG

system, being prospective in nature, will sometimes undercompensate for a given service and will sometimes overcompensate. The expectation, however, is that in the aggregate an efficiently operated hospital will receive an appropriate amount to reimburse it for medicaid services.

Unquestionably, Pennsylvania's PPS treats in-state hospitals differently than out-of-state hospitals. Rate calculation for in-state hospitals depends on the type of hospital seeking reimbursement and the average cost for that type of hospital. Under the PPS, all participating in-state hospitals, approximately 233 in number, are assigned to one of seven groups. Grouping for in-state hospitals takes into account four concepts: teaching status, medicaid volume, environmental characteristics, and hospital costs. These four concepts are measured by a total of thirteen variables, including such things as the number of resident and intern programs, total number of patients, area wage index, and so on. The actual grouping of in-state hospitals is accomplished by a computer program.

After classifying the in-state hospitals, Pennsylvania then determines a group average cost per case, which is based on actual allowable costs and adjusted for inflation and budget neutrality. The hospitals in Group 1 have the highest group rate, and those in Group 7 have the lowest.

To determine the amount of reimbursement to in-state hospitals under the PPS, Pennsylvania multiplies the relative value of the DRG by the hospital's group average cost per case. The higher the group rate, the higher the payment for a given DRG. Thus, Pennsylvania pays a Group 1 hospital more to treat a given DRG than it pays a Group 2, 3, 4, 5, 6, or 7 hospital to treat that DRG.

Out-of-state hospitals, on the other hand, receive quite different treatment under the PPS. Unlike in-state hospitals, out-of-state hospitals are not grouped according to the concepts of

hospital costs, teaching status, medicaid volume, and environment. Instead they are treated on the basis of one factor only: their geographical location outside Pennsylvania. Moreover, the group rate assigned to out-of-state hospitals is not based on the average allowable costs of that group based on historical data, but rather on the average of payments made to in-state hospital providers. To reimburse inpatient operating costs of out-of-state hospitals, Pennsylvania multiplies the relative value of the DRG assigned to the patient's illness by the Pennsylvania statewide average cost per case or pays the hospital's actual charges for treating that illness, whichever is lower.

Aside from operating cost reimbursement under the PPS, the MAP provides in-state hospitals additional hospital reimbursement on the basis of two other considerations: direct medical education costs (DME) and capital costs. Again, out-of-state hospitals are treated differently with respect to these two bases of medicaid reimbursement.

In-state hospitals receive an amount, in addition to their operating cost reimbursements, to reimburse them for the direct medical education (DME) costs (if any) associated with their medicaid service. For the years 1984 to 1986, Pennsylvania reimbursed in-state hospitals for the MAP share of their DME costs on an actual cost basis subject to certain limitations. Beginning fiscal year 1986-1987, Pennsylvania limits reimbursement to in-state hospitals for DME costs to 1.9 percent over the amount paid the hospital for DME costs the previous year, or the hospital's allowable DME costs, whichever is lower.

In contrast, Pennsylvania decided as a matter of policy not to pay out-of-state hospitals for DME costs associated with medicaid. Thus, teaching hospitals such as WVUH receive no DME cost reimbursement from Pennsylvania when they treat Pennsylvania medicaid patients.

Finally, in addition to reimbursement of inpatient operating costs under the PPS and in addition to payments for DME costs, Pennsylvania reimburses in-state hospitals for their allowable capital costs. For the period July 1, 1984 through June 30, 1986, reimbursement of in-state hospitals' capital costs was based on actual capital costs incurred. After that date, Pennsylvania initiated a prospective payment system for reimbursement of in-state hospitals' capital costs to be phased in between July 1, 1986, and June 30, 1992. During that period, Pennsylvania would pay in-state hospitals for their actual capital costs on a decreasing percentage basis. After July 1, 1992, the state will reimburse all in-state hospitals at the same flat rate for their capital costs.

Out-of-state hospitals are not reimbursed for their capital costs in the same manner. The Pennsylvania medicaid prospective payment system has never reimbursed out-of-state hospitals using actual allowable costs of capital. Pennsylvania pays out-of-state hospitals an "add-on" for capital reimbursement that represents the average capital costs of all Pennsylvania hospitals. That "add-on" bears no relationship to the actual capital costs of out-of-state hospitals. Moreover, although the MAP gave in-state hospitals approximately ten years to adjust to a flat rate payment for capital costs, out-of-state hospitals were allowed no phase-in period to adjust to a prospective payment system for such costs.

B. The MAP appeals system.

Pursuant to federal regulation, the state medicaid agency must provide hospitals with a system by which to appeal. In Pennsylvania the administrative agency division that adjudicates the appeals is the DPW's Office of Hearings and Appeals (OHA). The OHA hearing officer recommends a decision to the Director of OHA, who either adopts or rejects the recommendation. Both parties have the right to request reconsideration from the Secretary of DPW. Outside of the administrative appeals process, review of the decision of the Director of OHA or the Secretary of

DPW may be sought through the judicial system of the Commonwealth of Pennsylvania.

II. THE DISTRICT COURT'S DECISION

WVUH initiated this action on July 16, 1986. After a six-day bench trial in May 1988, the district court concluded that in all aspects -- operating costs, DME costs, and capital costs -- Pennsylvania's reimbursement program fell considerably short of the requirements of Title XIX and violated federal law. Moreover, the court concluded that Pennsylvania's classification of hospitals, affording different treatment to hospitals depending on their location inside or outside the state, violated WVUH's rights under the equal protection clause of the United States Constitution. Finally, the court declared Pennsylvania's administrative appeal system invalid because it allowed a hospital to challenge only the application of the state's methodology, rather than the methodology itself. The court ordered Pennsylvania to revise its medicaid reimbursement program and administrative appeals system as they applied to WVUH and to allow the Hospital to employ the revised appeal system to challenge reimbursements from the date the action was commenced. Pursuant to 42 U.S.C. § 1988, the district court awarded attorneys fees, which included expert witness fees, to WVUH as the prevailing party. The defendants appeal.

III. WVUH's RIGHT TO CHALLENGE THE REIMBURSEMENT PROGRAM

Before assessing the validity of Pennsylvania's medicaid reimbursement program, we first address the preliminary question whether WVUH has a cause of action entitling it to challenge the program.

The threshold issue in this case is whether WVUH can assert a cause of action against the defendant state officials under 42 U.S.C. § 1983 for alleged violation of the federal medicaid statute. Section 1983 provides in relevant part that:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or . . . the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983. Pennsylvania argues that a hospital cannot state a valid claim under section 1983 for alleged violation of the medicaid statute with respect to hospital reimbursement. This court has not previously had the opportunity to rule on this question of law.

Section 1983 provides a remedy for deprivation under color of state law of "any rights . . . secured by the Constitution and laws." 42 U.S.C. § 1983 (emphasis added). Interpreting this language in Maine v. Thiboutot, 448 U.S. 1 (1980), the Supreme Court held that the phrase "and laws" does not implicitly refer only to equal rights laws (making only equal rights violations actionable under section 1983), but rather refers generally to all federal statutory law. The plain language of section 1983, together with its legislative history and the Court's past treatment of the provision, compels the conclusion that causes of action under section 1983 are not limited to claims based on constitutional or equal rights violations. 448 U.S. at 6-8.

Thiboutot, however, does not stand for the broad proposition that section 1983 provides a cause of action for any violation of any federal law. As subsequent cases explain, a cause of action

under 1983 exists for violation of a federal law if two requirements are met. First, the federal law must create private rights enforceable under section 1983. Pennhurst State School and Hospital v. Halderman, 451 U.S. 1 (1981). In Pennhurst the Court held that a section 1983 action did not lie for alleged violation of the Developmentally Disabled Assistance and Bill of Rights Act because that Act conferred no substantive rights but merely constituted a congressional declaration of policy. Id. at 18-27. With respect to the existence of the private rights requirement, valid federal regulations as well as federal statutes may create rights enforceable under section 1983. Wright v. City of Roanoke Redevelopment and Housing Authority, 479 U.S. 418, 431-32 (1987) (HUD regulations defining statutory term "rent" as including a "reasonable amount" for utilities grants tenants rights enforceable under section 1983); Alexander v. Polk, 750 F.2d 250, 259 (3d Cir. 1984) (WIC regulation creates enforceable right to notice of fair hearing).

Second, and stated negatively, the federal law must not reflect a congressional intent to foreclose private enforcement. Middlesex Cty. Sewerage Auth. v. National Sea Clammers Ass'n, 453 U.S. 1 (1981). In Sea Clammers, the Court held that a cause of action for violation of two federal environmental statutes did not lie because the comprehensive remedial schemes provided in those statutes reflect a congressional intent to foreclose a private remedy under section 1983. Id. at 21. The burden of proving a congressional intent to foreclose a section 1983 remedy, however, lies with the state actor, and that burden is not easily satisfied. Once it is determined that a federal provision creates an enforceable right, a cause of action exists under section 1983 for violation of that provision "unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." Wright, 479 U.S. at 423. A court deciding the issue may not

"'lightly conclude'" that Congress intended such foreclosure. Id. at 423-24 (quoting Smith v. Robinson, 468 U.S. 992, 1012 (1984).[1]

Undertaking the analysis, then, the first question is whether the Medicaid Act, Title XIX of the federal Social Security Act, 42 U.S.C.A. §§ 1396 through 1396s (West 1983 & Supp. 1989), creates private rights in favor of hospitals participating in a state's medicaid program. Following the example set by the Court in Pennhurst, we seek the answer to this question in the language, purpose, and legislative history of the statute alleged to have been violated.

---

1 WVUH in its supplemental brief urges us to apply the test articulated in Cort v. Ash, 422 U.S. 66 (1975), for determining whether a statute implies a private right of action. The Hospital should be happy that we refuse its request and instead apply the traditional, and, coincidentally for it, more favorable analysis to determine private enforceability under § 1983. Whether a federal statute is enforceable under § 1983 and whether the statute creates an implied right of action involve separate inquiries. See, e.g., Middlesex Cty. Sewerage Auth. v. National Sea Clammers Ass'n, 453 U.S. 1, 19 (1981).

For the sake of clarity, we briefly explain the difference between a § 1983 private right of action analysis and the general implied right of action analysis of Cort v. Ash. When a statute does not explicitly supply a private right of action, two occasionally intersecting avenues may be explored for a possible private right of enforcement. First, an implied private right of action to enforce the statute may exist directly under the statute in accordance with the four-factor analysis of Cort v. Ash. To establish an implied right of action under Cort v. Ash, the plaintiff must satisfy the first requirement -- that the statute creates a federal right in favor of the plaintiff. The plaintiff must then satisfy the three remainig Cort v. Ash requirements relating to the existence of a remedy -- that Congress intended to create a remedy, that the remedy is consistent with the legislative scheme, and that the cause of action is not traditionally relegated to state law. In sum, under Cort v. Ash the plaintiff bears the burden of establishing not only the existence of a right, but also the existence of an intended private remedy.

Generally, the Medicaid Act consists of numerous sections and subsections that together form a cooperative mosaic through which the federal government reimburses a portion of the payments made by participating states to hospitals and other providers furnishing care to eligible needy persons. States participating in the program are charged with administering the medicaid plan and distributing the state and federal funds. Participation in the program is voluntary, but once a state chooses to participate it is obligated to devise a medicaid plan that complies with the federal statutory and regulatory conditions of funding. See Pennhurst, 451 U.S. at 11 (state participation in federal-state cooperative program to treat developmentally disabled carries obligation to comply with federal law).

Section 1396a of the medicaid act enumerates the various federal requirements of state medicaid plans. In particular, subsection 1396a(a)(13)(A) imposes federal requirements on states' reimbursement to hospitals and other entities providing care to medicaid patients. It is this subsection that WVUH charges the defendants violated, and it is to this subsection, therefore, that we turn to ascertain whether it created substantive

---

In appropriate cases, the second avenues for private enforcement of a federal statute is § 1983. In determining whether a private right of action exists under § 1983, only two inquiries are relevant: one, whether the statute alleged to have been violated creates a federal right in favor of the plaintiff, and the other, whether Congress has forclosed the remedy of private enforcement. The § 1983 analysis intersects with the Cort v. Ash analysis insofar as the plaintff under both analyses must establish the creation of a federal right. With respect to the existence of a remedy, however, the contrast between the two analyses is stark. Under Cort v. Ash the plaintiff must establish that Congress intended the remedy. Under § 1983 analysis, on the other hand, once a federal right is established, the existence of a remedy is presumed because § 1983 itself provides the authorization for private enforcement. The burden is on the defendant to establish that Congress intended to foreclose private enforcement.

private rights enforceable under section 1983 in favor of hospitals offering care to medicaid patients.

We begin with the statutory language. Section 1396a(a)(13)(A) stipulates, in pertinent part, that

> A State plan for medical assistance must -- . . .
>
> (13) provide --
>
> (A) for payment . . . of the hospital . . . services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . . .

42 U.S.C.A. § 1396a(a) (West Supp. 1989) (emphasis added). The language of this subsection is "cast in the imperative," see Alexander v. Polk, 750 F.2d at 259, mandating the state to maintain at least some sort of standard (the nature of which is better left for the merits discussion) in its hospital reimbursement plan. The language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or "'nudge,'" Pennhurst, 451 U.S. at 19 (quoting Rosado v. Wyman, 397 U.S. 397, 413 (1970)), in the direction of providing appropriate reimbursement of hospitals treating medicaid patients.

The construction of this subsection treating hospital reimbursement is parallel to the construction of the other forty-nine provisions imposing federal requirements on state

medicaid programs. All provisions are prefaced by the language that "[a] State plan for medical assistance must . . . ." There can be no mistaking that the stipulations of section 1396a(a) clearly constitute conditions that a state must meet to participate in the joint program.

In this respect, the statutory language of section 1396a(a) differs from the language examined in Pennhurst. In that case, the Court held that the "bill of rights" provision of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6010, did not create in favor of the mentally retarded any substantive rights to "appropriate treatment" in the "least restrictive environment." The Court compared the "bill of rights" provision with other sections of the act and observed that "[n]oticeably absent from 6010 is any language suggesting that 6010 is a 'condition' for the receipt of federal funding under the Act," making section 6010 stand "in sharp contrast" to the other sections that manifestly were conditions. 451 U.S. at 13. The Court's concern in Pennhurst that a state might not realize that its participation in a federal-state program is subject to federal conditions is relieved here by the express and imperative language of the Medicaid Act.

Defendants assert, however, that the purpose of the medicaid program weighs against finding that section 1396a(a)(13)(A) affords substantive rights to hospitals offering care to medicaid patients. They argue that imposing federal requirements with respect to hospital reimbursement does not equate with granting substantive rights in favor of hospitals to legally enforce reimbursement. The Medicaid Act helps states to fund a public assistance medical program for the financially needy, and therefore, defendants conclude any benefit conferred on hospitals is purely incidental. The beneficiaries of the act, argue defendants, are the needy persons assisted by medicaid, not the providers from whom the state buys medical services.

We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights only to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement. The section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus the hospitals are the section's "beneficiaries." Their interests and the interests of medicaid patients are bonded by a common goal, the delivery of adequate health care by the hospitals to state medicaid patients and the enjoyment of such care by the patients. The interests of both are intertwined and hospitals have a concrete stake in reimbursement in accordance with the federal statute and regulations.

Other courts have allowed health providers to challenge state medicaid plans as violative of Title XIX because they considered the interests of health providers and of medicaid patients to be "parallel." See, e.g., Coos Bay Care Center v. Oregon, Dep't of Human Resources, 803 F.2d 1060, 1063 (9th Cir. 1986) (private health care facility's challenge of medicaid program states a claim under section 1983), cert. granted, 481 U.S. 1036, vacated as moot, 108 S. Ct. 52 (1987); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1296 (8th Cir. 1985) (long-term medical care facilities may maintain section 1983 action challenging medicaid plan). Although we approve of these cases, their reasoning may sometimes suggest that they are concerned with a sort of representative standing rather than the creation of federal rights in favor of the health providers.

We prefer to ground our decision more explicitly and precisely on our conclusion that Title XIX affords enforceable rights to hospitals serving medicaid patients. In this respect, we join with the Fourth Circuit, which recently arrived at the same conclusion

after full analysis of the issue, see Virginia Hosp. Ass'n v. Baliles, 868 F.2d 653, 657-61 (4th Cir. 1989), petition for cert. filed (June 15, 1989), and the Tenth Circuit, which adopted the Fourth Circuit's reasoning and result in a like case. See Amisub, Inc. v. Colorado Dep't of Social Services, No. 88-2482, slip op. at 10 (10th Cir. July 11, 1989). Cf. Silver v. Baggiano, 804 F.2d 1211, 1217 (11th Cir. 1986) (expressly reserving question whether Social Security Act creates a right enforceable by a health provider under section 1983). Furthermore, once it is determined that WVUH has a private enforceable right under section 1983, we have no doubt as to its standing to bring this action. See Amisub, slip op. at 11.

The legislative history of section 1396a(a)(13)(A) buttresses our conclusion that WVUH has a private right to enforce the federal hospital reimbursement standard. In the Joint Explanatory Statement of the Committee of Conference commenting on the 1981 OBRA as enacted, Congress expressed its concern that state reimbursement methodologies adequately compensate hospitals for their care of medicaid patients. The report states: "the conferees intend that State hospital reimbursement policies should meet the costs that must be incurred by efficiently-administered hospitals in providing covered care and services to medicaid eligible as well as the costs required to provide care in conformity with State and Federal requirements." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess., 962, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, 1324. The same report also emphasizes the inclusion in the Title XIX amendment of a provision "providing that the States, in developing their payment rates, take into account the situation of hospitals . . . which serve a disproportionate number of low income patients." Id. We believe that Congress's concern with appropriate hospital reimbursement implies an intent to supply hospitals with an indispensable right to enforce state compliance with federal standards that, whether strictly or loosely, govern state reimbursement methodologies. Who else is more aggrieved by the absence of an adequate or reasonable hospital

reimbursement rate than a disadvantaged hospital and who has a more compelling interest to press for a correction? We therefore conclude that the beneficiaries of section 1396(a) are the hospitals that serve medicaid patients and that they have an enforceable private right.

Having determined that Title XIX supplies WVUH with private rights enforceable under section 1983, we next inquire whether the medicaid statute reflects a congressional intent to foreclose private enforcement. In accordance with the law as we described it above, WVUH has a remedy under section 1983 to enforce its rights under Title XIX unless defendants demonstrate that Congress intended to preclude private enforcement of that federal law.

Pennsylvania argues that Title XIX reflects a congressional intent to foreclose private enforcement of hospitals' rights because the statute requires the Department of Public Welfare to provide hospitals with an administrative remedy and because all state medicaid plans are subject to review by the Secretary of Health and Human Services and disapproval of a plan may result in suspension or reduction of federal payments. We believe, however, that Pennsylvania fails to carry its burden of proving that these remedial devices are "'sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under 1983.'" Wright v. City of Roanoke Redevelopment & Housing Auth., 479 U.S. 418, 424 (1987) (quoting Sea Clammers, 453 U.S. at 20). Title XIX gives no indication that the cut-off of funds to the federal agency is intended to supplant a section 1983 remedy. As the Supreme Court has recently held, "the existence of a state administrative remedy does not ordinarily foreclose resort to 1983." Wright, 479 U.S. at 427-28 (citing Patsy v. Board of Regents of Florida, 457 U.S. 496, 516 (1982)). Moreover, we fail to perceive how the cut-off of funds in futuro to the state agency effectively reimburses a hospital for services rendered to the state's medicaid patients in the past. We therefore conclude

that WVUH states a valid claim under section 1983 for enforcement of its rights under the Social Security Act.[2]

IV. THE VALIDITY OF PENNSYLVANIA'S HOSPITAL REIMBURSEMENT PROGRAM

We now arrive at the heart of this case -- whether Pennsylvania's plan for reimbursing out-of-state hospitals for their inpatient services to Pennsylvania medicaid recipients complies with federal statutory and regulatory law. The answer requires a close examination of Title XIX, its objectives, its legislative history, and its implementing regulations.

Section 1396a(a)(13)(A) provides in relevant part as follows:

> A State plan for medical assistance must -- . . . provide -- . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital . . . and periodic audits by the State of such reports . . . .

42 U.S.C.A. § 1396a (West Supp. 1989). This section, as we read it, authorizes states to develop their own medicaid reimbursement standards and methodologies for payment of hospital services, but subjects those standards and methodologies to three general federal requirements.

The first requirement, deriving from the parenthetical modifying "rates," mandates that a state's reimbursement rates take into account the situations of those hospitals serving a disproportionate number of low income patients. The second and third requirements, found in the phrase following that parenthetical, require a state to find that its rates are reasonable and adequate to meet the necessary costs of an efficiently operated hospital and to assure medicaid patients of reasonable access to inpatient hospital care. The first requirement we term the "disproportionate share" requirement, the second, the "reasonable and adequate" requirement, and the third, the "reasonable access" requirement. The federal regulations implementing section 1396a(a)(13)(A), 42 C.F.R. §§ 447.250-447.280, reiterate these statutory demands.

Our assessment of compliance with these three requirements is informed by the goals and purposes of the medicaid statute as reflected in its structure and legislative history. Section 1396a(a)(13)(A) was enacted as part of the 1981 Omnibus Budget Reconciliation Act, 95 Stat. 357, (OBRA) in an effort to contain the spiraling costs of inpatient hospital services and to reduce potentially stifling and expensive federal oversight of state

2 We note that exhaustion of state administrative remedies is not a prerequisite to an action under § 1983. Robinson v. Block, 869 F.2d 202, 207 n. 5 (3d Cir. 1989).

methodologies. See Colorado Health Care Ass'n v. Colorado Dep't of Social Services, 842 F.2d 1158, 1165 (10th Cir. 1988) (discussing purposes of the Boren Amendment); Wisconsin Hosp. Ass'n v. Reivitz, 733 F.2d 1226, 1228 (7th Cir. 1984) (same). As explained in the House report accompanying an earlier version of the statute, Congress intended by section 1396a(a)(13)(A) to free states from the previous "reasonable cost" criterion and to encourage them to develop prospective reimbursement systems that would foster hospital efficiency and reduce medicaid costs. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 292. States were to be allowed "greater latitude" and "greater flexibility" in designing their programs. See id. at 293; S. Rep. No. 139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong. & Admin. News 396, 744.

The states' discretion in devising new reimbursement standards and methodologies, however, was limited by the Congress's concern that medicaid recipients have reasonable access to medical services and that hospitals treating a disproportionate share of poor people receive adequate support from medicaid. Thus, a state's reimbursement rates may not be so low as to compel the closing of a dangerous number of hospitals or of a single medically important hospital, and thus compel medicaid recipients to travel an unreasonable distance to obtain medical care. See H.R. Rep. No. 158, 97th Cong., 1st Sess. 294 (expressing concern that rates not be so low as to discourage hospitals from treating medicaid patients). Moreover, because hospitals treating a large volume of medicaid patients are at the same time of singular importance to the health care of the poor and often already financially distressed, states must take into account these hospitals' special circumstances in setting reimbursement rates. See id. at 294-296 (discussing special needs and high social value of hospitals serving disproportionate number of poor people); H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, 1324 ("The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income

population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.")

We believe that this scheme also contemplates a deferential standard of review by the courts in assessing compliance with the "reasonable and adequate" requirement of section 1396a(a)(13)(A). Applying a higher standard would run counter to the congressional intent that states be afforded considerable freedom in pursuing ways of limiting medicaid costs and encouraging efficiency. On the other hand, neither state budgetary restraints nor chauvinistic policies designed to curb access to out-of-state hospitals[3] can excuse a failure to conform to the federal "reasonable and adequate standard," Wisconsin Hosp. Ass'n, supra at 1235. In evaluating whether Pennsylvania's rates are "reasonable and adequate" to meet the costs of an efficiently

---

3 At oral argument before us the following colloquy occurred between the court and counsel for the State:

> MR. FOERSTER: And the assumption was made that we had no evidence to the contrary, and still haven't, that the experience out-of-state as a whole is any different from the experience in state: that these hospitals would have about the same amount of medicaid utilization as does the average in-state hospital.
>
> THE COURT: If that's true, then why shouldn't West Virginia Hospital be factored in on the same basis as the Pennsylvania hospitals?
>
> MR. FOERSTER: Again I could only go back to what I answered before, the considerations that keep the money in-state, the treatment in-state, the marketing too.

Tr. 19-20.

operated hospital, we will not engage in an independent assessment of what rates we believe would be reasonable and adequate. Rather, we will only inquire whether the state's determination was arbitrary and capricious. See Mississippi Hospital Ass'n v. Heckler, 701 F.2d 511, 516 (5th Cir. 1983).

At the same time, however, we believe that compliance with the remaining two federal requirements -- reasonable access and disproportionate share -- is subject to our plenary review. The legislative history manifests Congress's strong concern that these requirements be invariably and fully satisfied. We will not presume to declare how the State must satisfy these requirements, but neither will we defer to the State's judgment that the requirements have indeed been met. With these standards of review in mind, we begin our evaluation of Pennsylvania's reimbursement program.

We question first whether Pennsylvania's reimbursement program as it applies to WVUH fulfills the disproportionate share requirement. See 42 C.F.R. § 447.253(b)(1)(ii)(A) (1988). The district court found that WVUH serves a disproportionate number of low income patients. Although only five percent of WVUH's admissions are Pennsylvania medicaid recipients, some thirty-eight percent of all WVUH admissions are low income persons.[4] The district court, appropriately taking a broad view of the issue, looked at WVUH's treatment of all low income patients, not just Pennsylvania medicaid patients, and found that the Hospital had established itself as a disproportionate share provider.

4 The district court found as a fact that in both fiscal years 1984-1985 and 1985-1986, WVUH treated in excess of 800 Pennsylvania medicaid patients. In fiscal year 1986-1987, it treated approximately 730 Pennsylvania medicaid patients. WVUH provided more care to Pennsylvaina medicaid residents than over one-half of the in-state hospitals for fiscal years ending June 10, 1986 and fiscal year ending June 30, 1987.

Pennsylvania, in its reimbursement system for in-state hospitals, accounts for disproportionate share through its grouping methodology for reimbursing operating costs. under Pennsylvania's in-state plan, medicaid volume is one of the four concepts that determine a hospital's assignment to one of seven hospital groups. A high medicaid volume may boost a hospital to a higher group rating, allowing the hospital to command a higher reimbursement rate per DRG. The methodology thus uses high medicaid volume as a proxy for disproportionate share of low income patients. In contrast, when Pennsylvania sets its reimbursement rates for out-of-state hospitals, it does not consider those hospitals' shares of low income admissions. Rather, Pennsylvania reimburses all out-of-state hospitals on the basis of the average payment it makes to in-state hospitals.

Significantly, Pennsylvania chose this method without first undertaking any studies examining the effects of its methodology on out-of-state low income providers. The State stipulated in the pretrial memorandum of undisputed facts that Pennsylvania did no empirical studies with respect to out-of-state payments and did not look at individual cost data for out-of-state hospitals. Moreover, the State stipulated that "[t]he out-of-state reimbursement methodology does not contain any provision with which to identify out-of-state hospitals serving a disproportionate share of low income patients and by which to reimburse those hospitals any more than other out-of-state hospitals are reimbursed." Appellee's Addendum of statutes, regulations, and stipulation of undisputed facts ¶ 133.

At oral argument, the State asserted that it accounted for disproportionate share of low-income providers when it determined the relative value of the DRG payment on the basis of in-state cost data. We fail to see, however, how this method fulfills the federal requirement. Pennsylvania assigned all out-of-state hospitals the average in-state payment rate, with no provision for increasing that rate on the basis of disproportionate share and no determination that the payment in itself would

account for the needs of disproportionate share of low-income providers. We see nothing in the development or implementation of the State's out-of-state reimbursement plan that demonstrates compliance with the federal mandate that rates account for disproportionate share. We therefore conclude that Pennsylvania's operating costs reimbursement system is invalid insofar as it fails to account for out-of-state hospitals' disproportionate share of low income admissions.

The second requirement of state medicaid plans is that their rates assure medicaid recipients of reasonable access to quality hospital care, taking into account geographic location and reasonable travel time. See 42 C.F.R. § 447.253(b)(1)(ii)(C) (1988).[5] Throughout the district court's opinion and the oral argument before us there ran an undercurrent of concern that inadequate reimbursement will encourage WVUH to close its doors to medicaid patients, leaving a considerable number of Pennsylvania residents without reasonable access to hospital care. At oral argument, defense counsel affirmed that without access to WVUH, some Pennsylvania medicaid patients would have to travel seventy miles or more to obtain tertiary hospital care. Moreover, the district court found, and Pennsylvania does not contest, that WVUH's withdrawal from the Pennsylvania medicaid plan would "jeopardize some Pennsylvania medicaid recipients' access to needed health care services." 701 F. Supp. at 509 (finding of fact # 181).

5 42 C.F.R § 431.52(b) requires that a state plan must provide that the State will furnish medicaid to : "(1) A recipient who is a recipient of the State while that recipient is in another State, to the same extent that medicaid is furnished to residents in the State," when the recipient meets certain prescribed conditions or "[i]t is general practice for recipients in a particular locality to use medical resources in another State."

The record establishes that the closing of WVUH to Pennsylvania medicaid patients would deprive some of those patients of reasonable access to needed health care. It is not, however, so clearly established that Pennsylvania's reimbursement system will result in the Hospital's withdrawal from the Pennsylvania medicaid plan, although there is a probability that it will withdraw because of the large number of Pennsylvania medicaid patients it treats and the substantial disparity in reimbursement between Pennsylvania medicaid recipients in Pennsylvania and those treated at WVUH. The district court found that inadequate medicaid reimbursement will have "substantial financial consequences for the Hospital and will jeopardize its continued ability to care for MAP patients." 701 F. Supp. at 509 (finding of fact # 180). The court also found that although on the average an in-state hospital is reimbursed for approximately ninety-five percent of its costs in treating a Pennsylvania medicaid recipient, WVUH recoups only about fifty-four percent of its costs in treating a Pennsylvania medicaid patient. In view of these facts, one can reasonably anticipate that WVUH will not continue indefinitely to treat Pennsylvania medicaid patients under the State's present reimbursement mechanism.

Nevertheless, the present record is somewhat incomplete on the point. There is no evidence that the Hospital has stopped treating medicaid patients, and the president of WVUH testified that WVUH has not yet seriously considered quitting the Pennsylvania medicaid plan. App. at 141a. We are therefore unprepared on this record to invalidate Pennsylvania's overall reimbursement plan as it applies to WVUH on the basis of nonfulfillment of the reasonable access requirement. Such a holding, we believe, would require remand to the district court for finding of the relevant facts. As explained infra, however, a remand will not be necessary in light of our conclusion with respect to compliance with the third federal requirement as well as our conclusion concerning the first federal requirement, supra at 30.

The third requirement imposed by section 1396a(a)(13)(A) is that the state must find that its rates are "reasonable and adequate" to meet the costs of an efficiently operated hospital.[6] Whereas the substantive dimensions of the first two requirements could be fairly drawn from the statute and its legislative history, discerning congressional intent with respect to the substantive element of the reasonable and adequate requirement is a more daunting project.

The states, we need hardly reiterate, enjoy broad discretion in devising their hospital reimbursement plans. The changes instituted by 1981 OBRA contemplated state experimentation with medicaid methodologies and certainly contemplated reduction in the outlay of medicaid funds. Importantly, the 1981 OBRA definitely contemplated that states would implement prospective payment systems that would not be based on actual costs. In promulgating regulations implementing section 1396a(a)(13)(A), the HCFA expressly refused to set a federal standard prescribing "reasonable and adequate" rates. It did observe, however, that "the term is not a precise number, but rather a rate which falls within a range of what could be considered reasonable and adequate." See 48 Fed. Reg. 56,046, 56,049 (Dec. 19, 1983). See also Colorado Health Care v. Colorado Dep't of Social Services, 842 F.2d 1158, 1167 (10th Cir. 1988) ("Reasonableness had been characterized as a zone, not a pinpoint.") (citing Reivitz, 733 F.2d at 1233).

It follows from the departure from a cost-driven reimbursement standard that a state's plan does not violate the substantive provision of the reasonable and adequate requirement simply because it fails to reimburse one efficiently operated hospital its actual costs. What matters, rather, as the State

6 The defendants have not asserted that WVUH is not an "efficiently and economically operated" facility.

vigorously argues, is whether the reimbursement rates to out-of-state hospitals in the aggregate are arbitrary and capricious.

Although Congress and the HCFA consciously declined to impose clearcut federal standards and requirements (with the exception of the reasonable access and disproportionate share requirements), the legislative history reflects congressional concerns that in turn may suggest some guidance as to what may constitute nonarbitrary reimbursement rates. The congressional reports concerning section 1396a(a)(13)(A) reflect a great sensitivity to the special needs of teaching and tertiary care hospitals. The House report accompanying an initial version of the statute states:

> The Committee intends States to recognize that facilities that provide teaching services or other specialized tertiary care services that may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by the States recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services . . . . Thus, while the Committee recognizes that in this time of economic constraint and reductions in Federal funds for Medicaid. States must be given the flexibility necessary to improve the Medicaid reimbursement mechanism, the Committee does not want such policies to result in arbitrary and unduly low reimbursement levels for hospital services.

H.R. Rep. No. 158, 97th Cong., 1st Sess. 294. The subsequent House conference report echoes the concern for teaching hospitals:

> The conferees recognize that public hospitals and teaching hospitals which serve a large medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a State take into account the special situation that exists in these institutions in developing their rates.

H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in U.S. Code Cong. & Admin. News 1010, 1324.

Teaching hospitals, the district court found and the defendants do not contest, incur greater costs than nonteaching hospitals in delivering the same service. 701 F. Supp. at 515. The court found that the bulk of a teaching hospital's direct medical education (DME) costs is made up of residents' salaries. And, the court continued, residents spend about seventy-five percent of their time administering patient care. Thus, the court concluded, reimbursement of DME costs is in large part a reimbursement for patient care. Id.

Pennsylvania's reimbursement methodology for in-state hospitals provides for increased payments to teaching hospitals. The reimbursement system for operating costs identifies teaching status as one of the four concepts relevant to grouping in-state hospitals. Teaching status may therefore increase a hospital's reimbursement per DRG. Moreover, above and beyond the operating costs reimbursement, the Pennsylvania program reimburses in-state teaching hospitals for the medicaid share of DME costs that the hospitals incur.

Pennsylvania recognizes that a teaching hospital will not be adequately reimbursed for the costs associated with its teaching

function if it is reimbursed at a rate deriving from the average indirect costs of teaching and nonteaching hospitals. 701 F. Supp. at 508. Moreover, Pennsylvania acknowledges that the failure of a payer to compensate for DME costs will necessarily shift those costs to another payer, and the failure of all payers to compensate for DME costs will eventually cause serious financial problems for the teaching hospital. Nevertheless, Pennsylvania provides no DME cost reimbursement to out-of-state hospitals.

Pennsylvania's justification is that it chose, as a matter of policy, not to reimburse the medicaid share of DME costs incurred by out-of-state hospitals in treating Pennsylvania medicaid patients because the state did not want to underwrite the medical education of residents and interns (even if some of them will be Pennsylvanian doctors)[7] at out-of-state hospitals. Pennsylvania's theory is "[n]othing in any law or regulation requires WVUH to be a teaching hospital." Thus, Pennsylvania presumes that rates would not be arbitrary even if they were to force WVUH to abandon its teaching role.

It is true that Congress did not specifically codify its manifest concern that medicaid rates be adequate to assure the continued existence of teaching hospitals. On the basis of only the statutory and regulatory language, there is therefore some merit to the proposition that rates fulfill the "reasonable and adequate" requirement, even if they do not reimburse DME costs, as long as they reimburse operating costs. Although it seems to strike a discordant note with the national agenda of the federal medicaid program, perhaps such state chauvinism as is displayed by Pennsylvania here might be tolerated under certain

---

7 The district court observed that some 7% of WVUH residents practice in Pennsylvania. Moreover, as the district court observed, some of the residents in Pennsylvania teaching hospitals will practice out of state, yet Pennsylvania's program helps finance their training.

circumstances. On the other hand, we must give some content to the notion of nonarbitrary rates, and we therefore turn again to the legislative history. That legislative history suggests that Congress intended teaching hospitals in general, not just those within state borders, to be adequately supported by medicaid plans. See supra at 35.

We hesitate, however, at this point to hold that Pennsylvania's refusal to reimburse out-of-state hospitals' DME costs is arbitrary and capricious and in violation of the reasonable and adequate requirement of section 1396a(a)(13)(A). We remain fully cognizant of the states' freedom to experiment with their reimbursement systems, and do not want unnecessarily to restrict it. Instead, withholding judgment on this aspect of the plan individually, we examine the plan as a whole.

Under Pennsylvania's plan, WVUH receives reimbursement for operating costs at the average rate of payment for all in-state hospitals (or based on the Hospital's actual charges, whichever is lower), notwithstanding WVUH's character as a teaching hospital ...t provides tertiary care and serves a disproportionate number of low income patients. Moreover, simply because WVUH is not an in-state hospital, it receives absolutely no DME cost reimbursement. Finally, unlike in-state hospitals, WVUH's is reimbursed for its capital costs on the basis of a rate that bears no relationship to its actual costs. Pennsylvania reimburses its in-state hospitals on the basis of a ten-year phase-in plan that pays in-state hospitals for their actual capital costs on a decreasing percentage basis. After the ten years, a uniform flat rate will apply. Contrast that system with the out-of-state reimbursement. Capital cost reimbursement to out-of-state hospitals consists of an "add-on" that represents the average capital costs of all in-state hospitals' actual costs. And out-of-state hospitals do not enjoy the benefit of a ten-year phase-in to adjust to the flat payment rate. WVUH is particularly distressed by the capital cost reimbursement system because it recently opened a replacement facility which greatly increased its capital costs.

As we note above, the district court found that this dual reimbursement system resulted in in-state hospitals on the average receiving approximately ninety-five percent of their costs in treating a Pennsylvania medicaid recipient, but WVUH is reimbursed only about fifty-four percent. Now, even if we were to conclude that it is not per se arbitrary and capricious to reimburse out-of-state hospitals on the basis of a flat in-state hospital average, or to reimburse out-of-state hospitals on a different (and presumably, here, lower) scale for capital costs, or not to reimburse them their DME costs at all, there still seems to be something seriously wrong with this reimbursement system. Can the zone of reasonableness possibly be so large as to encompass percentages of cost reimbursement for Pennsylvania medicaid recipients ranging from fifty-four to ninety-five?

The HCFA, in declining to define certain statutory terms, stated that "the State's methods and standards implicitly act as the State's definition of an efficiently and economically operated facility." 48 Fed. Reg. 56,046, 56,049 (Dec. 19, 1983). To some extent, the same is true of the term "reasonable and adequate." Pennsylvania, by virtue of the federal statute and regulations, holds its in-state program out as reasonably and adequately reimbursing efficiently operated hospitals. At the same time, however, Pennsylvania impliedly makes the same assertion with respect to its fifty-four percent reimbursement of medicaid costs incurred by an out-of-state tertiary hospital. Our role is to determine whether Pennsylvania can nonarbitrarily make that assertion.

In the face of such great disparity in the reimbursement rates between its in-state hospitals and WVUH, Pennsylvania must show a rational basis for its medicaid reimbursement program. As other courts have explained, a "state must articulate a 'rational connection between the facts found and the choice made.'" Colorado Health Care Ass'n, 842 F.2d at 1167 (quoting Baltimore Gas & Elec. Co. v. Natural Resources Defense Council, Inc., 462

U.S. 87, 105 (1983)). Pennsylvania, we conclude, wholly fails to offer such a rational basis.

Pennsylvania's preference of its own hospitals does not justify undercompensating out-of-state hospitals that are serving Pennsylvania patients under a federal program. The State is not merely exercising discretion in how to spend its own money; medicaid funds derive in large part from the federal government. Nothing in Title XIX remotely suggests that a state may use federal funds to give its own hospitals preferential treatment and, at the same time, disadvantage out-of-state hospitals. In establishing the new federal standards for hospital reimbursement rates in section 1396(a)(13)(A), OBRA's legislative history notes that although the Committee recognized that the current economic constraints and need of reductions in federal funds for medicaid requires that states be given the flexibility necessary to improve the medicaid reimbursement mechanism, "the Committee does not want such policies to result in arbitrary and unduly low reimbursement levels for hospital services." H.R. Rep. No. 158, 97th Cong., 1st Sess. 293-94 (1981). Nothing in section 1396(a) speaks in terms of a dichotomy in rate reimbursement built on state boundary lines; it nowhere suggests that state boundary lines act as points of demarcation in reimbursement for the delivery of health care. Under the federal regulations, supra at n. 6, state boundary lines, except for administrative responsibility, bear an insignificant role, if any, with respect to the actual delivery of health care in a program designed on a national level to aid the poor in a highly mobile society.

Moreover, Pennsylvania's excuse of administrative burden does not, in this case, provide a rational basis for WVUH's grossly diminished reimbursement rates. Pennsylvania argues that it would be too time and resource consuming to account for the characteristics and costs of out-of-state hospitals, and that deriving flat rates from the universe of in-state hospitals and applying them to out-of-state hospitals provides a reasonable

solution. Although this argument may become valid at some point, it is not valid in this case. WVUH undisputedly is the largest out-of-state provider of health care to Pennsylvania medicaid patients. It serves more of these Pennsylvania patients than over half of the Pennsylvania hospitals. Although we do not suggest that audits and calculations be made for all out-of-state hospitals, the retrieval and evaluation of relevant information from WVUH, and other significant out-of-state providers,[8] would not pose any particular administrative burden. It is simply irrational and arbitrary, not too mention patently unfair, to refuse to do so when the result is a system that various so wildly in its reimbursement rates for hospitals whose "[m]edical services are needed," 42 C.F.R. § 431.52(b), to serve Pennsylvanians. We therefore conclude that the Pennsylvania medicaid program as it applies to WVUH is violative of federal law because it fails to meet the reasonable and adequate requirement of section 1396a(a)(13)(A).

We neither hold nor suggest that Pennsylvania must apply precisely the same methodology to WVUH and other out-of-state hospitals as it does for its in-state hospitals if there is a rational basis for a departure. The methodology applied, however, must be rational, not arbitrary or whimsical. Nor do we suggest that Pennsylvania is precluded from formulating an acceptable reimbursement system to out-of-state hospitals without empirical evidence concerning their historical costs of operation so long as its reimbursement rates fall within the range of "rates reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."

---

8 The district court found that Pennsylvania could audit 75-100 more hospitals each year without increasing its audit staff.

Finally, although not necessary to the outcome of the case given the preceding discussion, we hold that in addition to the substantive provisions Pennsylvania violated the procedural requirements of Title XIX. The three federal provisions discussed above contain both a procedural and a substantive dimension. The procedural dimension is explicit in the federal regulations implementing section 1396a(a)(13)(A). These federal regulations condition HCFA approval of a new state plan on the state's assurances that it has complied with the regulatory requirements. 42 C.F.R. § 447.253 (1988). One of these regulatory requirements is that the State make findings in support of its change in medicaid plan. Essentially, the State is required to find that its new plan complies with the three substantive requirements discussed above. Section 447.253(b) of the HCFA regulations provides:

> (b) Findings. Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:
>
> (1) Payment rates. (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.
>
> (ii) With respect to inpatient hospital services --
>
> (A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs; [and]
>
> * * * *
>
> (C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

42 C.F.R. § 447.253(b) (1988).

In structuring its out-of-state reimbursement program, Pennsylvania admits to gathering no information with respect to these hospitals' actual costs. No empirical analysis was conducted to measure the effects of the reimbursement program on out-of-state hospitals. Pennsylvania did not even identify its large out-of-state providers. Federal law is not satisfied if a state merely makes conceptual policy decisions. A policy predicated upon provincialism and self-interest, now upon findings of reasonableness and adequacy, is unacceptable. We hold that the federal regulations unambiguously require the State to make findings, and in so doing they do not distinguish between out-of-state and in-state hospitals. In failing to make these requisite findings, Pennsylvania violated federal law.[9]

---

9 The district court held that Pennsylvania's out-of-state reimbursement program violated not only Title XIX, but also the equal protection rights of WVUH guaranteed by the fourteenth amendment. Although we have serious reservations concerning this treatment of the equal protection rights issue by the district court, we dispose of this case on statutory grounds and therefore see no need to reach the constitutional issue.

V. THE VALIDITY OF THE ADMINISTRATIVE APPEALS SYSTEM

Our last inquiry with respect to Pennsylvania's medicaid program is whether the district court correctly concluded that the program's administrative appeals system is legally inadequate. For our answer, we must again look to section 1396a and its implementing regulations to ascertain whether Pennsylvania comports with federal law.

Title XIX requires states participating in the medicaid program to institute an appeals procedure by which providers may challenge their payment rates. 42 U.S.C. 1396a(a)(37) (West Supp. 1989); 42 C.F.R. § 447.253(c). The federal regulation states:

> Provider appeals. The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. § 447.253(c). It is undisputed that, at least at the hearing level, Pennsylvania's appeals procedure allows providers to challenge their payment rates on the ground of the application of the state's reimbursement methodology; it does not allow providers to challenge the validity of the methodology itself. See 701 F. Supp. at 510 (finding of fact # 197). The district court, after review of the federal regulation and the relevant legislative history, held that this procedure was insufficient.

Our review of the federal law, however, leads us to conclude otherwise. On September 30, 1981, the HCFA published interim final regulations. 46 Fed. Reg. 47964-47973. Because "individual facility rates will not receive Federal review under the revised

regulations," the HCFA required in one of its regulations that states participating in the medicaid program develop an appeals procedure by which individual facilities could request review and adjustment of their rates. The regulation stated:

> The agency must provide an appeals procedure that allows individual providers an opportunity to submit additional evidence and request prompt administrative review of payment rates.

Fed. Reg. p. 47972. The HCFA noted, however, that it was open to suggestions on how best to guarantee review of payment rates and it invited comments on its provider appeals regulations.

Some two years later, the HCFA reviewed the comments it received and promulgated the final regulation quoted above. In its accompanying commentary, the HCFA rejected suggestions that it establish minimum criteria defining the scope of review of payment rates. The agency wrote:

> We also believe that establishing minimum criteria for appeals and penalty clauses for frivolous appeals in the regulation would be contrary to the statutory intent allowing States greater flexibility in developing more cost effective reimbursement systems. Moreover, the States, not the Federal government, are in the best position to determine the administrative process that would best meet their needs and be most compatible with their reimbursement system. However, States are free to establish reasonable criteria for appeals to limit the issues on appeal that may be appropriate or to adopt other procedures to prevent frivolous appeals.

48 Fed. Reg. 56046, 56052 (Dec. 19, 1983). Consistent with the hands-off philosophy reflected in this commentary, the HCFA rewrote the appeals regulation to require an appeals procedure

for payment rates "with respect to such issues as the agency determines appropriate." 42 C.F.R. § 447.253(c).

We believe that this permissive language giving the agency greater authority to select the issues for determination permits the state agency to reject review of challenges to the validity of its methodology in its administrative appeals system. In the situation of a uniform rate, which describes Pennsylvania's reimbursement of out-of-state hospitals, such a limited appeals system may not seem the best approach. See Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891, 903 (E.D. Va. 1985) (observing that "the more general the rate-setting system is, the stronger the need for some appropriate method of accommodating particular situations that the general rules do not adequately address."). However, we conclude that the language of the federal regulation, in keeping with the federal policy to contain health costs and give states great flexibility in the administering of medicaid, reserves to the judgment of the states the decision whether to allow challenges to the validity of the methodology at the administrative level.

By so holding, we do not mean to imply that the language licenses the states to virtually eliminate all appeals by choosing to deem no issues appropriate for appeal. Implicit in the regulation is, we believe, a requirement that at least correct calculation of the payment rate is a mandatory issue for appeal. In this respect, it is significant that the HCFA rejected a suggestion that the appeals process requirement be waived in states adopting uniform statewide reimbursement rates. 48 Fed. Reg. 56052. By requiring an appeals procedure even in that situation, the regulation appears to contemplate that at least some issue is appealable, and the logical conclusion is that the essential and dominant appealable issue is rate calculation. Pennsylvania allows appeals by providers pursuant to 1 Pa. Code §§ 35.1-35.251. Canonsburg Gen. Hosp. v. Department of Health, 422 A.2d 141 (1980). Appeals raising the incorrect calculation of the rate may be appealed from a hearing officer's determination to the Director of OHA or the Secretary of the Department and then to the

Commonwealth Court. See Northwestern Inst. of Psychiatry v. Commonwealth, 513 A.2d 495, 498 (Pa. Commw. 1986); Grand Oak Nursing Home v. Commonwealth, 541 A.2d 800, 802 (Pa. Commw. 1986).

We conclude that the federal regulation requires no more of the State's appeals procedure than Pennsylvania offers. We reserve therefore the district court's judgment invalidating Pennsylvania's appeals system.[10]

VI. EXPERT WITNESS FEES UNDER 42 U.S.C. § 1988

After its decision on the merits, the district court in an exercise of its discretion under 42 U.S.C. § 1988[11] awarded attorneys fees to WVUH as the prevailing party in a section 1983

10 In light of our disposition with respect to the administrative appeals procedure, we have no cause to consider the eleventh amendment issue raised in the district court and pursued on appeal. The district court's judment ordering Pennsylvania to revise its appeals procedure and to apply it to WVUH for reimbursement claims dating from the commencement of this action raised serious eleventh amendment concerns about whether this remedy was retroactive relief unavailable against the state in federal court. Because we uphold the appeals system and issue only prospective relief from the day of judgment, the eleventh amendment is not implicated by our decision.

11 Section 1988 provides in pertinent part:

> In any action or proceeding to enforce a provision of [section 1983], the court, in its discretion, may allow the prevailing party, other than the United States, a reasonably attorney's fee as part of the costs.

42 U.S.C.A. § 1988 (West 1981).

action. Following the parties' joint proposal on the amount of fees, the court awarded the Hospital $500,000. Of this amount $350,000 was allocated to attorneys fees, $45,867 to disbursements, and $104,133 to expert witness fees. The defendants unsuccessfully contested the award of expert witness fees before the district court, arguing that such fees are statutorily limited to thirty dollars a day by 28 U.S.C. § 1821(b). On appeal the defendants do not challenge an award of expert witness fees in general, but they do renew their argument that the amount of expert witness fees improperly exceeded the statutory maximum.

The defendants' argument rests on the Supreme Court's decision in Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437 (1987). In Crawford Fitting the Court held that a federal court taxing expert witness fees as costs under Fed. R. Civ. P. 54(d) could not exceed the statutory maximum of thirty dollars a day contained in 28 U.S.C. § 1821(b). The statutory framework underlying that decision is as follows. Rule 54(d) provides that costs shall be taxed against the losing party unless the court otherwise directs. The modern day codification of the 1853 Fee Act, 28 U.S.C. § 1920, in turn enumerates the various costs that may be assessed against a party, and these costs include "[f]ees and disbursements for printing and witnesses." Another statute, 28

U.S.C. § 1821(b), sets the amount of compensation to be paid witnesses at thirty dollars a day.[12]

The petitioners in Crawford Fitting, argued that federal courts had discretion under Rule 54(d) to award costs above and beyond those listed in section 1920 and in excess of the amount provided in section 1821. The Court rejected petitioners' contention, concluding that their view of Rule 54(d) as authorizing courts to decide what is taxable as a cost would render section 1920 superfluous. 437 U.S. at 441. Thus, because section 1920 listed witness fees as a taxable cost, and because section 1821(b) authorized witness compensation of only thirty dollars a day, the Court held that expert witness fees taxed as costs against the losing party under Rule 54(d) could not exceed section 1821(b)'s statutory cap. 437 U.S. at 445.

The defendants ask us to apply Crawford Fitting to expert witness fees awarded as part of an attorneys fee under 48 U.S.C. § 1988. They assert that the broad ruling of Crawford Fitting precludes awarding of expert witness fees in excess of thirty

---

12 Section 1821 provides in relevant part:

> (a)(1) Except as otherwise provided by law, a witness in attendance at any court of the United States . . . shall be paid the fees and allowances provided by this section.
>
> ***
>
> (b) A witness shall be paid an attendance fee of $30 per day for each day's attendance. A witness shall also be paid the attendance fee for the time necessarily occupied in going to and returning from the place of attendance at the beginning and end of such attendance or at any time during such attendance . . . .

28 U.S.C.A. § 1821 (West Supp. 1989).

dollars a day, even though those fees are assessed as part of an attorneys fee under the fee-shifting statute of section 1988 rather than as a run-of-the-mill cost taxed as of course in favor of the prevailing party under Rule 54(d). The Hospital, on the other hand, argues that Crawford Fitting's reach does not extend to section 1988, and that expert witness fees assessed under that section are not subject to a statutory cap.

Section 1988 is a statutory exception to the general American Rule disallowing shifting of attorneys fees. Applicable in civil rights cases, the statute states that a court may award to the prevailing party "a reasonable attorney's fee as part of the costs." In construing section 1988, courts developed the general principle that incidental expenses incurred by the attorney, and not usually absorbed as overhead but rather charged to the client, may be included as part of an "attorney's fee" under section 1988. See Bartell, Taxation of Costs and Awards of Expenses in Federal Court, 101 F.R.D. 553, 592-94 (gathering cases).

Depending on the law of the circuit, the "expenses" allowable as part of an attorneys fee have sometimes included expert witness fees. See Ramos v. Lamm, 713 F.2d 546, 559 (10th Cir. 1983) (expert witness fees reimbursable under section 1988 if "reasonably necessary" to case); Heiar v. Crawford County, 746 F.2d 1190, 1203 (7th Cir. 1984) (expenses of litigation "distinct from either statutory costs or the costs of the lawyer's time reflected in his hourly billing rates," including expert witness fees, are part of attorneys fee under section 1988). But see Wheeler v. Durham City Bd. of Educ., 585 F.2d 618, 624 (4th Cir. 1978) (fees of expert witnesses "are traditionally not regarded as attorney's fees," however essential their services to the successful preparation and trial of a complex case). In our own circuit, we have followed the rule, not limited to civil rights cases but certainly applicable in a section 1988 case, that a district court has the equitable discretion to award expert witness fees in excess of the section 1821 statutory amount if "the expert's testimony is indispensable to determination of the case." See Roberts v. S.S. Kyriakoula D. Lemos, 651 F.2d 201, 206 (3d Cir. 1981); see also Rank v. Balshy, 590 F. Supp. 787, 801 (M.D. Pa. 1984) (expert witness fees allowable as part of attorneys fee under section 1988 in excess of thirty dollars a day).

The Hospital and the defendants stipulated that WVUH's experts were indispensable to the case, and the district court independently expressed its heavy reliance on their testimony. Under the rule in this circuit, WVUH normally would be entitled to expert witness fees in excess of the statutory maximum. The issue before us, however, is whether Crawford Fitting repudiates the previous law with respect to enhanced awards of expert witness fees under section 1988.

The Hospital argues, and the district court agreed, that Crawford Fitting does not apply to fees awarded under section 1988. The argument has much merit. Justice Blackmun, concurring in Crawford Fitting, and Justices Marshall and Brennan, dissenting, all emphasized that the Court in that case did not reach the question whether a court may award excess expert witness fees under section 1988. 482 U.S. at 445 (Blackmun, J., concurring); id. at 446 n. 1 (Marshall, J., dissenting). Moreover, the policy underlying section 1988, that of making the prevailing party whole, would suggest that the rule of cost taxation embodied in Crawford Fitting should not apply in the context of attorneys fee shifting in civil rights actions. In his strong concurrence in International Woodworkers v. Champion Int'l. Corp., 790 F.2d 1174, 1181-1193 (5th Cir. 1986), aff'd sub nom. Crawford Fitting Co. v. J.T. Gibbons, Inc., 482 U.S. 437 (1987). Judge Rubin makes the forceful argument that based on the legislative history of the Civil Rights Attorney's Fees Awards Act of 1976, Congress intended to treat expert witness fees like all other litigation expenses and include them as part of the attorneys fee awardable under section 1988.

Indeed, a number of courts examining the question raised here have concluded that Crawford Fitting does not limit expert witness fees awards under section 1988 to the rate set in section 1821(b).[13]

On the other hand, the broad language of Crawford Fitting strongly suggests that we reach the opposite conclusion. Although on its facts a Rule 54(d) case, the substance and reasoning in Crawford Fitting seems to dictate that, even in the case of a fee shifting statute such as section 1988, a court may not award fees in excess of the statutory maximum of thirty dollars a day unless the fee shifting statute expressly makes such an allowance. The Court wrote that it "will not lightly infer that Congress has repealed §§ 1920 and 1821, either through Rule 54(d) or any other provision not referring explicitly to witness fees." 482 U.S. at 445. Moreover, the Court plainly expressed its disfavor for "[a]ny argument that a federal court is empowered to exceed the limitations explicitly set out in sections §§ 1920 and 1821 without plain evidence of congressional intent to supersede that section." Id. at 445.

---

13 See Sapanajin v. Gunter, 857 F.2d 463, 465 (8th Cir. 1988) (holding that because expert witness fee award was not made as a taxation of costs under section 1821 but as an expense under section 1988, the cap on fees set out in Crawford Fitting does not apply); Black Grievance Comm. v. Philadelphia Elec. Co., 690 F. Supp. 1393, 1403 (E.D. Pa. 1988) (same); Hillburn v. Comm'r of Conn. Dep't of Income Maintenance, 683 F. Supp. 23, 27 (D. Conn. 1987), aff'd 847 F.2d 835 (2d Cir. 1988) (same); United States v. Yonkers Bd. of Educ., 118 F.R.D. 326, 330 (S.D.N.Y. 1987) (same); cf. Mathis v. Spears, 857 F.2d 749, 758-59 (Fed. Cir. 1988) (post-Crawford case holding section 1821 inapplicable to award of expert witness expenses under fee-shifting statute pertaining to patents); Freeman v. Package Machinery Co., 865 F.2d 1331, 1346-47 (1st Cir. 1988) (although not reaching issue, strongly suggesting it would not "elongate" Crawford Fitting to apply in context of express fee shifting statute).

We believe that the recent decision of the Court in Missouri v. Jenkins, 47 U.S.L.W. 4735 (1989), in no way alters the ruling of the Court in Crawford. Unlike Crawford, which dealt with witness fees statutorily fixed by Congress as part of the costs, the Court in Jenkins dealt with a comparatively new phenomenon in the legal world, the enhancement of attorney's fees by including the fees for services of paralegals and law clerks. Their fees, however, are not regulated by statute as are witness fees. In fact, Missouri, against whom the fees were taxed, conceded "that compensation for the cost of these personnel should be included in the fee award." Id. at 4738. Missouri's argument was that section 1988 did not authorize billing paralegals at market rates, but only at their cost to the attorneys hiring them; charging market rates produced a windfall for the attorney.

We acknowledge that in this age of sophisticated litigation, in which expert witnesses play an increasingly important role, thirty dollars per day is an insignificant sum. However, we believe that we are constrained by the language of Crawford to abandon our previous rule and to limit expert witness fees to thirty dollars a day. Congress has chosen to legislate in this area and unless the statute under which expert witness fees are awarded expressly repeals the limits of sections 1920 and 1821(b), we must defer to legislative fiat. In so holding, we join with the other circuits interpreting Crawford Fitting that have arrived at the same conclusion with respect to fee-shifting statutes similar to section 1988. Denny v. Westfield State College, 58 U.S.L.W. 2077 (1st Cir. 1989) (holding in a Title VII sex discrimination case that absent some reasonably explicit indication of Congressional intent that witness fees be shifted without regard to the thirty dollars per day cap, the Crawford rule must prevail). See Glenn v. General Motors Corp., 841 F.2d 1567, 1575 (11th Cir.), cert. denied, 109 S. Ct. 378 (1988) (holding section 1821) applicable to fee-shifting provision of Equal Pay Act because "the broad language in Crawford Fitting does not permit a distinction based upon whether or not the award is made under a fee-shifting statute"); Leroy v. City of Houston, 831 F.2d 576, 584 (5th Cir. 1987), cert.

denied, 108 S. Ct. 1735 (1988), (holding section 1821 applicable to fee-shifting provision of Voting Rights Act); cf. Gilbert v. City of Little Rock, 867 F.2d 1062, 1062-63 (8th Cir. 1989), petition for cert. filed (May 20, 1989) (en banc) (affirming by an equally divided court the order of the district court awarding expert witness fees as expenses under section 1988 at the statutory rate of thirty dollars a day); Boring v. Kozakiewicz, 833 F.2d 468, 474 (3d Cir. 1987), cert. denied, 108 S. Ct. 1298 (1988), (stating in dicta that under Crawford Fitting "[a] prevailing party in a civil rights case is not entitled to tax such fees as costs"); see also Central Delaware Branch of NAACP v. City of Dover, 123 F.R.D. 85, 94-95 (D. Del. 1988) (awarding expert witness fees under section 1988 at statutory rate of thirty dollars a day).

We thus conclude that, under Crawford Fitting, section 1988 as presently drafted does not authorize expert fee awards in excess of the statutory cap of thirty dollars per day provided in section 1821(b). We therefore vacate the district court's judgment awarding attorneys fees insofar as it awards WVUH expert witness fees in excess of thirty dollars per day.

VII. CONCLUSION

We conclude that WVUH can assert a cause of action against the defendants under 42 U.S.C. § 1983 for violation of the federal medicaid statute and that statute does not reflect a congressional intent to foreclose private enforcement. Although states possess broad discretion in devising their hospital reimbursement plans under the medicaid statute, we hold that overall the Pennsylvania medicaid program as it applies to WVUH violates federal law because it fails to meet the disproportionate share and the reasonable and adequate requirements of section 1396(a)(13)(A) and the procedural provisions of Title XIX.

As for Pennsylvania's administrative appeals system, we conclude that it sufficiently satisfies Title XIX and the

implementing federal regulation. Finally, the district court's award of expert fees in excess of thirty dollars per day exceeded federal statutory provisions.

Accordingly, the judgment of the district court declaring the Commonwealth of Pennsylvania's medicaid prospective system as it applies to WVUH in violation of federal law will be affirmed as well as its order directing the defendants to formulate a methodology within ninety days from the day of judgment for its medicaid prospective payment system for WVUH consistent with and in conformity with federal law. Reimbursement to WVUH under a prospective payment system that conforms to federal law will commence with the date of the district court's initial judgment in this matter. The judgment of the district court declaring Pennsylvania's administrative appeals system as it applies to WVUH in violation of federal law will be reversed. The judgment of the district court with respect to attorney's fees will be vacated insofar as it grants expert witness fees in excess of thirty dollars per day.

Two-thirds of WVUH's costs on appeal will be taxed against the appellants.

A True Copy:

Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.,	)	
Plaintiff	)	
	)	CIVIL ACTION NO. 86-0955
v.	)	
ROBERT CASEY, Governor, et al.,	)	
Defendants	)	

MEMORANDUM

Background

West Virginia University Hospitals, Inc. (WVUH or the Hospital) commenced this action against the Commonwealth of Pennsylvania's Department of Public Welfare and individuals on July 26, 1986. Pursuant to stipulation, the Department of Public Welfare was dismissed as a defendant on February 25, 1987. WVUH brought this action under 42 U.S.C. section 1983 alleging Pennsylvania's medicaid reimbursement program for out-of-state hospitals violates federal payment standards and violates the equal protection clause of the fourteenth amendment of the United States Constitution. Plaintiff further alleges Pennsylvania's administrative appeals system for out-of-state hospitals is legally inadequate. The Hospital seeks injunctive and declaratory relief regarding its past treatment under Pennsylvania's reimbursement program and administrative appeals system. The trial in this action took place before the court on May 2, 3, 4, 5, 6, and 16, 1988. The parties have been given an opportunity to present arguments and proposed findings of fact and conclusions of law. The opinion of the court follows.

Findings of Fact

In accordance with Federal Rule of Civil Procedure 52(a) the court finds the following facts.

I. The Parties

1. WVUH is a non-stock, non-profit corporation organized under the laws of West Virginia. Plaintiff's Pretrial Memorandum Undisputed Facts No. 1. (Hereinafter referred to as "Facts.")

2. Defendant Robert P. Casey is the Governor of the Commonwealth of Pennsylvania. Facts 2.

3. The Secretary of the Department of Public Welfare (the Secretary) of Pennsylvania was Walter C. Cohen at the time this action was filed. The Secretary is now John F. White, Jr. Facts 3.

4. The Secretary reports to the Governor of Pennsylvania. The Secretary is responsible for implementing, administering and operating the medicaid program in Pennsylvania. The Medicaid program in Pennsylvania is called the "Medicaid Assistance Program" (MAP). Facts 4.

5. Since November, 1987, David S. Feinberg has been Acting Director of the proposed Office of Hospital and Outpatient Programs in the Department of Public Welfare (the Department or DPW). From 1979 to November, 1987, Feinberg was the Director of the Bureau of Policy and Program Development. Facts 5.

Feinberg was responsible for the development of Pennsylvania's medicaid program's prospective payment system. Facts 6.

II. The Hospital

7. WVUH is located six miles south of the border between the State of West Virginia and the Commonwealth of Pennsylvania. Facts 10.

8. The primary service area of the Hospital includes the West Virginia counties of Monongahela, Marion, Harrison, Taylor, Doddridge and Preston and the Pennsylvania counties of Fayette and Greene. Facts 11.

9. Generally, Pennsylvania residents constitute approximately 16% of all WVUH inpatient admissions. Testimony of Katherine Douglass, Transcript[1] at 163, lines 6, 15-17.

10. In 1985, 2,500 inpatient admissions to WVUH were attributable to Pennsylvania residents. 860 of the admissions were Pennsylvania medicaid recipients. Testimony of Katherine Douglass, Transcript at 163, lines 15-20.

11. Approximately 204,000 people lived in Fayette and Greene counties in the mid-1980s. By the late 1980s, the population in Fayette and Greene counties is projected to grow to 209,000 people. Testimony of Katherine Douglass, Transcript at 158, lines 20-25.

12. 1,200 persons from Fayette County received inpatient care at WVUH in 1985; 1,100 persons from Greene County received

---

1 Citations to "Transcript" refer to the trial transcript. Because some trial testimony was transcribed on an expedited basis during trial, citations to that testimony will be, for example, "May 4, 5, and 6, 1988 Transcript." Deposition testimony will be cited similarly i.e., "December 28, 1986 Vertrees Deposition."

inpatient care. Testimony of Katherine Douglas, Transcript at 163, lines 21-25; 164, lines 1-7.

The Hospital also serves patients from Washington County, Pennsylvania. In calendar year 1985 the Hospital had 102 Pennsylvania medicaid admissions from Washington County, Pennsylvania. Facts 14.

Services Provided

14. A "tertiary care" hospital is a hospital that provides a level of hospital and medical services that is inherently more complex and that is generally not provided in small or community hospitals. Testimony of Bernard Westfall, Transcript at 33, lines 2-25; 34, lines 1-25; 35 lines 1-15.

15. WVUH is the closest source of tertiary care services to many individuals living in Greene and Fayette counties. Testimony of Katherine Douglass, Transcript at 159, lines 11-25; 160-161; 162, lines 1-24.

16. Some Pennsylvania medicaid recipients who reside in Fayette, Greene and parts of Washington counties, and who must use the Hospital for complex or specialized medical services, otherwise must travel 20 to 70 additional miles to Pittsburgh, Pennsylvania, the next closest city (to the Hospital) in which such services are offered. Facts 16.

17. Specialized or complex inpatient services available at the Hospital which are not available in the Pennsylvania hospitals in Fayette, Greene, and Washington counties include cardiac catheterization, angiography, open heart surgery, high risk obstetrics, neonatal intensive care, kidney transplant lithotripsy. Testimony of Katherine Douglass, Transcript at 159, lines 16-25; 160, lines 1-25; 161, lines 1-25; 162, lines 1-25; 163, lines 1-25; 164, lines 1-25; 165, lines 1-25; 166, lines 1-3. Facts 17.

18. WVUH is a Level I trauma center equipped to deal with head and spine injuries as well as cardiac and other emergencies. It is the only Level I trauma center in the service area of WVUH. The next closest Level I trauma center is located in Pittsburgh. Testimony of Katherine Douglass, Transcript at 160, lines 11-25; 161, lines 1-5.

19. WVUH provides an extensive prenatal referral system for high risk neonates and, as apart of that system, provides high risk prenatal services to hospitals in the service area, including Greene County Memorial Hospital located in Greene County, Pennsylvania. Testimony of Katherine Douglass, Transcript at 161, lines 6-25; 162, lines 1-24.

20. WVUH also provides specialized outpatient services to Pennsylvania residents. These services include pediatric cardiology, pediatric neurology, neurosurgery, and other highly technical types of care. Testimony of Katherine Douglass, Transcript at 165, lines 16-22.

21. The outpatient services identified in the paragraph above are not available at hospitals located in Fayette and Greene counties. If patients did not use WVUH for such services, the next closest hospital would be located in Pittsburgh. Testimony of Katherine Douglass, Transcript at 165, lines 23-25; 166, lines 1-3.

22. WVUH also provides Pennsylvania residents with routine hospital care such as routine obstetrics, normal newborn care and tonsillectomies. Defendants' Exhibit 76.

23. The types of routine cases seen at WVUH are similar to the routine types of cases seen at most university teaching hospitals. Testimony of James Vertrees, Transcript at 77, lines 8-14.

24. WVUH has approximately the same Case Mix Index (CMI) as university teaching hospitals located in Pennsylvania and other similarly situated hospitals. Plaintiff's Exhibit 66.

WVUH is a University Affiliated Teaching Hospital

25. The Hospital is a university affiliated teaching hospital: the West Virginia University uses the Hospital to train health professionals. Facts 39.

26. WVUH is a major academic medical center, one of only 121 such centers in the country. Testimony of Gerard Anderson, Transcript at 392, lines 1-12.

27. 1,300 persons completed their physician and dentist residency training programs at the Hospital between 1960 and 1984. Facts 40.

28. Approximately 7% of the 1,664 total living alumni of the West Virginia University School of Medicine's four-year medical program live in Pennsylvania. Facts 47.

29. MAP recognizes that the provision of graduate medical education programs improves the quality of care at a hospital. Testimony of Gerard Anderson, Transcript at 320, lines 12-23. Plaintiff's Exhibit 8.

WVUH's Medicaid Volume

30. Historically, WVUH has provided significant numbers of Pennsylvania medicaid recipients with hospital care.

31. In Calendar year 1981, the Hospital treated 610 Pennsylvania medicaid admissions on an inpatient basis. Facts 22.

32. In calendar year 1982, the Hospital treated 692 Pennsylvania medicaid admissions on an inpatient basis. Facts 23.

33. In calendar year 1983, the Hospital treated 783 Pennsylvania medicaid admissions on an inpatient basis. Facts 24.

34. In calendar year 1984, the Hospital treated 828 Pennsylvania medicaid admissions on an inpatient basis. Facts 25.

35. In calendar year 1985, the Hospital treated 853 Pennsylvania medicaid admissions on an inpatient basis. Facts 26.

36. In calendar year 1986, the Hospital treated 840 Pennsylvania medicaid admissions on an inpatient basis. Facts 27.

37. In calendar year 1987, the Hospital treated 552 Pennsylvania medicaid admissions from the period January 1 through September 30, 1987. Facts 28.

38. The number of patients identified in paragraphs 31 through 37 above does not include the number of Pennsylvania medicaid recipients who utilized the outpatient services of the Hospital. Facts 29.

39. The annual number of outpatient visits at the Hospital attributable to Pennsylvania medicaid recipients ranges from 7,000 to 7,500. Facts 30.

40. Pennsylvania medicaid recipients residing in Fayette, Greene, and Washington counties have "freedom of choice" in selecting their medical care providers. This means absent special rules, (none of which are applicable to this case), Pennsylvania recipients of medicaid may use the services of any hospital they choose. Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 124, lines 22-25; 125, lines 1-25; 126, lines 1-25; 127, lines 1-21.

41. Some Pennsylvania residents, including Pennsylvania medicaid recipients, living in the counties of Fayette, Greene, and

Washington desire and require access to the Hospital's services and facilities. Facts 32.

42. In fiscal years 1984-85, 1985-86 and 1986-87, WVUH provided inpatient hospital care to more Pennsylvania medicaid patients than over one-half of the hospitals located in Pennsylvania. Testimony of Thomas Manak, Transcript at 251, lines 8-25; 252, lines 1-7. Plaintiff's Exhibit 51(a).

43. Five percent of all WVUH inpatient admissions are attributable to Pennsylvania medicaid recipients. Testimony of Stephen Pickett, Transcript at 170, lines 12-13; 175, lines 18-20.

44. In addition to serving Pennsylvania recipients, the Hospital served the following numbers of West Virginia medicaid admissions on an inpatient basis:

July 1, 1982 - June 30, 1983	2,049
July 1, 1983 - June 30, 1984	2,261
July 1, 1984 - December 31, 1984	1,181
Calendar Year 1985	2,319
Calendar Year 1986	1,848
January 1, 1987 - October 31, 1987	1,618

45. Twenty-three percent of all WVUH inpatient admissions are recipients of medicaid. Testimony of Stephen Pickett, Transcript at 170, lines 8-9.

46. Seventeen percent of all WVUH inpatient admissions are West Virginia medicaid recipients. Testimony of Stephen Pickett, Transcript at 170, lines 12, 13.

WVUH's Incorporation History

46. In 1982 the West Virginia Board of Regents commissioned a study to determine how to resolve deficiencies cited by the national accreditation board for hospitals. The West Virginia Board of Regents was advised that given the structural problems of the existing facility, it was more prudent to replace the facility than to renovate it. Testimony of Bernard Westfall, Transcript at 49, lines 22-25; 50, lines 1-25; 51, lines 1-25; 52, lines 1-19.

48. The West Virginia legislature concurred. See 18-11C-2(c) of the Code of West Virginia.

49. The entity that the legislature created to operate the facility is WVUH. Testimony of Bernard Westfall, Transcript at 59, lines 18-20.

50. WVUH and its predecessor entity, West Virginia University Hospital, are the same. They are both creatures of the West Virginia legislature and subject to its control. The legislature simply changed the form of the hospital organization. Testimony of Bernard Westfall, Transcript at 142, lines 12-25.

51. The West Virginia legislature has never relinquished ownership of the Hospital's assets and control. Plaintiff's Exhibit 71. See 18-11C-3 of the Code of West Virginia.

52. The change from West Virginia University Hospital to WVUH was a change in the form of organization, not a change of ownership or control. Testimony of Bernard Westfall, Transcript at 142, lines 12-25; 688, lines 3-13; 690, lines 5-25; 691, lines 1-7.

The Provider Agreement with MAP

53. West Virginia University Hospital, the predecessor entity to WVUH, entered into an agreement with the Pennsylvania Medicaid Assistance Program. Defendants' Exhibit 35.

54. The provider agreement, which was not dated, is self-perpetuating unless terminated. Defendants' Exhibit 35.

55. The defendants have never terminated the provider agreement. Testimony of Donna Hoffmaster, Transcript at 482, lines 6-9.

56. MAP has reimbursed WVUH for inpatient services provided to Pennsylvania medicaid patients without interruption, except for one seven week interruption beginning in December, 1987. The reason for withholding payment was due to an alleged failure to report a change in ownership. Testimony of Amy Leopard, May 3, 1988, Transcript at 7, lines 3-25; 8, lines 1-25; 9, lines 1-25; 10, lines 1-13; Plaintiff's Exhibit 67; letter dated December 2, 1987 from Virginia Antonoplos.

57. The payments were interrupted and withheld after MAP employees consulted with counsel for MAP. The interruption of payments was related to this litigation. Testimony of Amy Leopard, May 3, 1988 Transcript at 13, lines 9-21.

58. The defendants offered no evidence demonstrating a change in West Virginia University Hospital's ownership. Defendants testified only that they were aware that WVUH uses a tax payer identification number for its short procedure unit (not related to inpatient care) that is different from some other numbers utilized by WVUH. Testimony of Donna Hoffmaster, Transcript at 477, lines 16-25; 478, lines 1-12.

III. Pennsylvania Medicaid Program Reimbursement of In-State Hospitals

The Nature of the Medicaid Program

59. Medicaid is a federal-state program that pays for medical services provided to the eligible poor in accordance with Title XIX of the Social Security Act and the applicable state and federal regulations. Facts 55, 57.

60. The state designs and administers the medicaid program within the broad parameters established by Title XIX of the Social Security Act, implementing federal regulations, and the applicable state laws and regulations. Facts 57.

61. Medicaid is a different program than Medicare. Medicare is a program of health insurance administered by the federal government. Facts 58.

62. The Commonwealth of Pennsylvania participates with the federal government in providing a medicaid program to eligible Pennsylvania residents. Facts 59.

63. As a part of its agreement with the federal government to participate in medicaid, the defendants submitted a state plan for medical assistance to the United States Secretary of Health and Human Services for approval. Facts 60.

64. Pennsylvania's state plan for medical assistance has been approved by the United States Secretary of Health and Human Services, including the Pennsylvania state plan provisions that govern reimbursement of general acute care hospitals which provide health care services to Pennsylvania medicaid recipients. Facts 61.

The Change From Retrospective "Reasonable Cost" Reimbursement to Prospective Reimbursement

65. Prior to 1981, the Social Security Act required states to pay hospitals the "reasonable cost" of rendering inpatient hospital services to medicaid recipients. Facts 62.

66. "Reasonable cost" was a term defined and used in the medicare program and adopted for use in the medicaid program. Facts 63.

67. As a general rule, the "reasonable cost" standard of reimbursement meant that states were required to reimburse hospitals their actual, allowable costs (capital costs and operating costs) of the care provided to medicaid recipients. Facts 64.

68. "Reasonable cost" reimbursement was a retrospective form of reimbursement, involving the payment of interim rates during the fiscal year with an end-of-year cost settlement once a hospital reported its claimed actual, allowable medicaid costs. A hospital's reported costs were generally subject to audit. Facts 65.

69. On July 31, 1981, the United States Congress enacted the Omnibus Budget Reconciliation Act of 1981, Public Law 97-35 (OBRA), which changed the requirement that state medicaid programs reimburse hospitals the "reasonable" cost of providing services. Facts 66.

70. Effective for fiscal year 1984-1985, the Commonwealth of Pennsylvania replaced the reasonable cost system of reimbursement for acute care inpatient services in hospitals in the medicaid program. Facts 72.

71. In place of the reasonable cost standard Pennsylvania adopted a "prospective payment system" for acute care inpatient services in hospitals. Facts 73.

72. Under a prospective payment system of reimbursement a hospital is told in advance what its payment will be for specified services. Facts 74.

73. The Pennsylvania prospective payment system was designed, in part, to implement the OBRA standard and to contain the rising cost of health care. Facts 75.

74. One of the goals of Pennsylvania's system of prospective payment is to provide hospitals with the incentive to become more efficient and economical by providing them a fixed amount of reimbursement for each case regardless of the provider's actual costs of treating those cases. Facts 76.

In-State Hospital Reimbursement of Operating Costs Of Inpatient Care Under The MAP Prospective Payment System Grouping

75. Under Pennsylvania's medicaid prospective payment system of reimbursement, all participating in-state hospitals were separated into seven groups, excluding children's hospitals. Facts 78.

76. The purpose of the grouping system was to place hospitals with similar roles and potential for costs in the same group. December 28, 1988 Deposition of James Vertrees at 35, lines 4-13; 53, lines 11-21. Defendants' Exhibit 2 at 2198.

77. The underlying assumption was that similar hospitals have similar costs and that reimbursement of the average cost of similarly situated hospitals would be an equitable means of payment. Testimony of Thomas Manak, Transcript at 213, lines 14-17.

78. Pennsylvania used a complex formula to identify the similarities among hospitals. Testimony of Thomas Manak, Transcript at 213, lines 18-19.

79. Pennsylvania's groupings for in-state hospitals take into account four concepts: each hospital's teaching status, its medicaid volume, its environmental characteristics, and its hospital costs. Facts 80.

80. Teaching status, medicaid volume, environmental characteristics, and hospital costs are measured by a total of thirteen variables. Facts 81.

81. The variables consist of, inter alia, the number of interns and resident programs, medicaid volume, area wage index, and total patients seen at the hospital. Testimony of Thomas Manak, Transcript at 214, lines 15-17.

82. The actual grouping of in-state hospitals is done by computer program after inputting each in-state hospital's data for the thirteen variables. Facts 82.

83. MAP has placed all in-state academic medical centers in Group I. Testimony of Kelly Grotzinger, Transcript at 60, lines 21-25; 602, lines 8-10.

Group Average Cost Per Case

84. After all in-state hospitals were grouped into seven groups by the computer, Pennsylvania determined a group average cost per case. This group average cost per case is ultimately used to determine the prospective payment. Facts 83.

85. To ascertain the group average cost per case for each of the groups of in-state hospitals for fiscal years 84-85, 85-86 and 86-87, the defendants identified each hospital's reported Pennsylvania medicaid reimbursable costs for the most recently completed fiscal year, subtracting certain costs specified in the state plan and applicable regulations. Facts 84.

86. The in-state hospital's costs were then divided by the number of Pennsylvania medicaid cases on paid claims history for that in-state hospital for that year. Facts 85.

87. The resulting figure was that particular in-state hospital's average cost per case for the fiscal year from which the cost information was derived. Facts 86.

88. The average cost per case for the hospital was then standardized by a hospital-specific case mix index. Facts 87.

89. The defendants then determined a rate of increase for each in-state hospital's average cost per case by the particular in-state hospital's average cost per case for the preceding fiscal year. Facts 88.

90. The defendants then adjusted the in-state hospital's average cost per case by an inflation rate, if the rate of increase was greater than the rate of inflation for the preceding fiscal year. Facts 89.

91. If the rate of increase was equal to or less than the rate of inflation, then the average cost per case was increased by one-half of the difference between the rate of increase and the rate of inflation for the preceding fiscal year. Facts 90.

92. The defendants projected the in-state hospital's average cost per case to the end of the forthcoming year by multiplying the adjusted average cost per case by a projected inflation rate for the forthcoming fiscal year. Facts 91.

93. For each group of in-state hospitals the defendants added the projected average cost per case for each in-state hospital in a given group, and divided the total by the number of hospitals in that particular group. Facts 92.

94. The resulting figure was the group average cost per case which was then adjusted for budget neutrality. This number was the group rate. Facts 93.

95. A group rate was calculated for each of the seven groups. The hospitals in Group 1 have the highest group rate. The hospitals in Group 7 have the lowest group rate. Testimony of Thomas Manak, Transcript at 220, line 25; 221, lines 1-17; 225, lines 16-24. Defendants' Exhibit 2 at 2198, 2199.

The Payment Rate for a DRG

96. To determine how much to pay a hospital for treating a patient with a given illness, MAP multiplies the relative value of the Diagnostic Related Group (DRG) assigned to the patient's illness by the hospital's group average cost per case. Testimony of Thomas Manak, Transcript at 224, lines 20-22.

97. The higher the group average cost per case, i.e., the hospital's group rate, the higher the payment for a given DRG. Thus, MAP pays a Group 1 hospital more to treat a given DRG than it pays a Group 2, 3, 4, 5, 6 or 7 hospital to treat the same DRG. Testimony of Thomas Manak, Transcript at 225, lines 16-25; 226 lines 1-3.

98. The payment amount for a given case may be adjusted for payments made by a third party payer, patient co-pay or resource obligations, or, if the case qualifies as a day or cost outlier. Facts 97.

99. Under Pennsylvania's prospective payment system, hospitals are paid a set amount per inpatient case for the hospital's operating costs based on the hospital's group rate and the applicable DRG. Facts 98.

100. The DRG system of reimbursement creates "winners" and "losers." A winner is a case where the DRG payment is

greater than the actual cost of treating a particular patient. A loser is where costs are more than the DRG payment received. Testimony of Gerard Anderson, Transcript at 314, lines 11-15.

101. On aggregate, the expectation is that over a large number of cases, in-state hospitals will be paid an appropriate amount. Testimony of Gerard Anderson, Transcript at 314, lines 24-25.

In-State Hospital Reimbursement of Direct Medical Education Costs

102. In addition to reimbursement of the inpatient operating costs for each inpatient case, MAP pays in-state hospitals an additional amount to reimburse them for their direct education medical costs, if any. Facts 101.

103. MAP reimburses in-state hospitals for their direct medical education (DME) costs in accordance with the federal medicare regulations and applicable state laws and regulations for such reimbursement. See Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 95, lines 3-8, 19-24; 96, lines 1-3.

104. In developing its payment system, MAP recognized that organized or planned educational activities enhance the quality of care in an institution. Plaintiff's Exhibit 8. Testimony of Gerard Anderson, Transcript at 320, lines 12-23.

105. In developing its payment system, MAP stated it wanted to fairly reimburse the legitimate costs of DME. Plaintiff's Exhibit 8.

106. The defendants concluded that reimbursement of DME costs satisfied the OBRA standard. Facts 145.

107. A hospital's direct medical education costs are largely the salaries hospitals pay to residents in approved teaching programs. Testimony of Michael Maher, Transcript at 642, lines 16-23.

108. Residents spend approximately 75% of their time providing direct patient care. Testimony of Gerard Anderson, Transcript at 321, lines 17-21.

109. MAP reimburses in-state hospitals for the MAP share of their DME costs on a "pass through" basis subject to certain limitations. Testimony of Thomas Manak, Transcript at 227, lines 14-25; 228, lines 1-2.

110. MAP has a specific line on its medicaid cost report for hospitals to report their DME costs. Testimony of Michael Maher, Transcript at 648, lines 6-12.

111. MAP reimbursed in-state hospitals for the MAP share of their DME costs in 1984-1985 and 1985-1986 on an actual cost basis subject to certain limitations. See 55 Pa. Code 1163.55. Defendants' Exhibit 2.

112. For fiscal year 1986-1987 and thereafter, MAP limits reimbursement to in-state hospitals for DME costs to 1.95% over the amount paid to the hospital in the previous year for DME costs or the hospital's allowable DME costs, whichever is less. See 55 Pa. Code 1163.55(d). Defendants' Exhibit 4.

113. In actual practice, MAP requires hospitals to claim resident salaries as part of the hospitals' cost of doing business. MAP does not give residents in approved training programs separate provider contracts. Testimony of Michael Maher, Transcript at 649, lines 19-25; 650, lines 1-18.

114. There is no provision of the Pennsylvania State Plan or other Pennsylvania rule that would permit interns and residents in approved teaching programs to bill MAP directly for their services instead of having hospitals claim their salaries as costs. Testimony of David Feinberg, May 4, 5 and 6, 1988 Transcript at 106, lines 23-25; 107, lines 1-5; 121, lines 1-16.

In-State Hospital Reimbursement of Capital Costs

115. In addition to reimbursement of the inpatient operating costs for each inpatient case and in addition to any payments for direct medical education costs, MAP reimburses in-state hospitals for their allowable capital costs. Facts 103.

116. For the period July 1, 1984 through June 30, 1986 this reimbursement for capital costs was determined for each in-state hospital by ascertaining each hospital's specific capital costs. Facts 104.

117. MAP then paid its share of the hospital's actual allowable costs on a pass-through basis. Testimony of Thomas Manak, Transcript at 227, lines 1-12.

118. For the period July 1, 1984 through June 30, 1986, the defendants found that the reimbursement of an in-state hospital's actual, allowable capital costs satisfied the OBRA standard. Facts 137.

119. After July 1, 1986, MAP initiated a prospective payment system for reimbursement of an in-state hospital's capital costs. The system will be phased in between July 1, 1986 and June 30, 1992. During this period, MAP will pay in-state hospitals for their actual capital costs on a decreasing percentage basis. After July 1, 1992, MAP will reimburse all in-state hospitals the same flat rate for their capital costs. Testimony of David Feinberg, May 4, 5 and 6, 1988 Transcript at 64, lines 6-24; 65, line 1.

The Phase-In of the Prospective Payment System for In-State Hospitals

120. The defendants adopted a three year phase-in for Pennsylvania's prospective payment system for reimbursement of each in-state hospital's operating costs. The phase-in began in fiscal year 1984-1985. Facts 105.

121. The phase-in involved blending each in-state hospital's group average cost per case with the in-state hospital's hospital specific cost per case. Facts 106.

122. In fiscal year 1984-1985, an in-state hospital's prospective payment rate was a blend of 75% of the in-state hospital's hospital-specific cost per case, after a budget neutrality adjustment, and 25% of the hospital's group average cost per case, after a budget neutrality adjustment. Facts 107.

123. In fiscal year 1985-1986, an in-state hospital's prospective payment rate was calculated by adjusting the percentages from 75%/25% to 50%/50%. Facts 108.

124. In fiscal year 1986-1987, the prospective payment rate of an in-state hospital was determined by using only that in-state hospital's group average cost per case. Facts 109.

IV. The Pennsylvania Medicaid Program: Reimbursement of Out-Of-State Hospitals

General

125. The Pennsylvania medicaid prospective payment system does not reimburse out-of-state hospitals the same way it reimburses in-state hospitals. Facts 117.

Reimbursement for Operating Costs

Grouping

126. Under the Pennsylvania prospective payment system all out-of-state hospitals are grouped together in one group -- irrespective of the differences that might exist between the hospitals, such as teaching status, medicaid volume, environment, and hospital costs. Facts 118.

127. Out-of-state hospitals are grouped using one factor only: the hospitals are not located in Pennsylvania. Facts 119.

128. By grouping all out-of-state hospitals together Pennsylvania did not put out-of-state hospitals with the potential for similar costs together. December 28, 1987 Deposition of James Vertrees at 54, lines 13-18.

129. Defendants determined as early as September 6, 1983 that the Pennsylvania medicaid prospective payment system would classify all out-of-state hospitals into one group and reimburse them for operating costs using an average in-state rate based on the statewide average cost per case. Facts 120.

130. The drafters of the MAP prospective payment system were aware that placing all out-of-state hospitals together in a group and basing their payment on an average Pennsylvania statewide cost per case was potentially inequitable for a large university medical center because teaching hospitals have extremely high costs. December 28, 1987 Deposition of James Vertrees at 54, lines 13-22. Plaintiff's Exhibit 11.

The Lack of a Factual Basis to Support the Payment Rate Used for WVUH

131. No empirical study was done with respect to out-of-state payments between the period September 6, 1983 and July 1, 1984 when the prospective system was implemented. Facts 122.

132. To reimburse inpatient operating costs of out-of-state hospitals, Pennsylvania multiplies the relative value of the DRG assigned to the patient's illness by the out-of-state group rate (based on a Pennsylvania statewide average cost per case) or the hospital's actual charges for treating that illness, whichever is lower. See 55 Pa. Code 1163.65(c).

133. In developing the reimbursement methodology for out-of-state hospitals, defendants did not look at the individual cost data for out-of-state hospitals. Facts 125.

134. Unlike the situation concerning in-state hospitals, the Pennsylvania medicaid payment rate for out-of-state hospitals has no relation to the actual costs incurred by the out-of-state hospitals in providing care to Pennsylvania medicaid recipients. Testimony of Thomas Manak, Transcript at 229, lines 4-5, 18-25; 230, lines 1-2.

135. The Pennsylvania medicaid payment rate is not sensitive to differences that may exist between out-of-state hospitals. Testimony of Thomas Manak, Transcript at 228, lines 20-24.

136. A small community hospital that is out-of-state will receive the same MAP payment for a given DRG that WVUH will receive. Facts 129.

137. MAP has no empirical analysis that validates the payment rates for out-of-state hospitals. Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 111, lines 6-14, 24-25; 112, line 2.

138. MAP has no factual basis for concluding that its operating cost reimbursement to WVUH is adequate and reasonable. Testimony of Gerard Anderson, Transcript at 244, lines 8-25; 345, lines 1-3, 12-20.

139. MAP defends its payment rate for out-of-state hospitals on the grounds that it was administratively too burdensome to identify and validate the costs of out-of-state hospitals. December 15, 1987 Deposition of David Feinberg at 28, lines 9-11. Testimony of David Feinberg May 4, 5, and 6, 1988 Transcript at 43, lines 4-21.

140. Few out-of-state hospitals see more than 20 MAP cases per year. Plaintiff's Exhibit 56(A). Testimony of Thomas Manak, Transcript at 257, lines 11-24.

141. WVUH is the only out-of-state hospital that serves more than 160 MAP cases. Plaintiff's Exhibit 56(A).

142. MAP did not identify its large out-of-state providers. Testimony of James Vertrees, Transcript at 550, lines 2-25; 551, lines 1-18.

143. MAP considered out-of-state reimbursement a minor, technical issue, not a substantive issue. Testimony of Robert Gallagher, Transcript at 607, lines 1-6.

144. MAP presently has the audit capacity to verify the costs of 75-100 out-of-state hospitals. Testimony of Robert Gallagher, Transcript at 607, lines 1-6.

MAP Did Not Consider Whether Out-of-State Hospitals Treat A Disproportionate Share of Low Income Persons

145. It costs more to treat low income patients and hospitals that serve a large medicaid population are "particularly dependent" on medicaid reimbursement. 48 Fed. Reg. 56048 (December 19, 1983).

146. The Pennsylvania medicaid prospective payment methodology defines a low income patient as a patient who is a Pennsylvania medicaid recipient. Testimony of Gerard Anderson, Transcript at 359, lines 22-25; 360, lines 1-12.

147. MAP considers an in-state hospital that has an 18-20% medicaid volume serves a disproportionate number of low income patients. Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 109, lines 1-4.

148. The out-of-state reimbursement methodology does not contain any provision with which to identify out-of-state hospitals serving a disproportionate share of low income patients and by which to reimburse those hospitals any more than other out-of-state hospitals are reimbursed. Facts 133.

149. MAP does not take into account the high volume of medicaid patients at WVUH. Testimony of Gerard Anderson, Transcript at 424, lines 10-11.

150. Adequate medicaid reimbursement is essential for hospitals that have a high volume of medical assistance patients because their medicaid payment is significant in terms of their total revenue picture. December 28, 1988 Deposition of James Vertrees at 34, lines 7-14.

151. MAP concluded that the flat average rate paid to out-of-state hospitals, if used in-state, would result in teaching hospitals not getting enough payment and smaller community hospitals getting more than they needed. MAP did not have a similar concern for out-of-state hospitals. Testimony of James Vertrees, Transcript at 561, lines 7-25; 562, lines 1-21.

Reimbursement of Capital Costs for Out-of-State Hospitals

152. Under the Pennsylvania medicaid prospective payment system Pennsylvania does not reimburse WVUH or other out-of-state hospitals for their capital costs in the same manner as Pennsylvania reimburses in-state hospitals. Facts 125.

153. The Pennsylvania medicaid prospective payment system has never reimbursed out-of-state hospitals using their actual allowable costs of capital. Facts 139.

154. The Pennsylvania medicaid prospective payment system pays out-of-state hospitals an "add-on" for capital reimbursement

that represents the average capital costs of all Pennsylvania hospitals. Facts 140.

155. The Pennsylvania "add-on" for capital costs to the reimbursement of out-of-state hospitals bears no relationship to the actual capital costs of those hospitals. Testimony of Thomas Manak, Transcript at 230, lines 7-15.

156. MAP gave in-state hospitals approximately 10 years to adjust to a flat rate payment for capital. Testimony of James Vertrees, May 6, 1988 Transcript at 78, lines 7-25; 79, line 1.

157. Out-of-state hospitals did not have a chance to adjust to a prospective payment for capital. Testimony of James Vertrees, May 6, 1988 Transcript at 79, lines 2-4.

158. Under the current Pennsylvania regulations that govern the medicaid prospective payment system, an out-of-state hospital that believes that the capital part of its payment is inadequate, cannot obtain more than that flat rate payment even if it can demonstrate that it has additional actual capital costs and that additional capital reimbursement is necessary to meet the costs of an efficiently and economically run institution. Deposition of David Feinberg at 164, lines 18-25.

159. Capital reimbursement is an important part of medicaid reimbursement because hospitals need to replace or expand their capital assets over time. Testimony of Gerard Anderson, Transcript at 364, lines 18-25; 365, lines 1-9.

160. WVUH's hospital facility has exhausted its useful life. Testimony of James vertrees, Transcript at 552, 18-22.

161. When WVUH opens its new facility, WVUH will have no opportunity to obtain relief from MAP, under existing regulations, to cover what it believes is the MAP share of the additional capital costs associated with the new construction.

Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 129, lines 6-25; 130, lines 1-7.

Reimbursement of Direct Medical Education Costs of Out-of-State Hospitals

162. Pennsylvania does not reimburse WVUH or any other out-of-state hospital for costs of DME attributable to Pennsylvania medicaid recipients. Facts 146.

163. WVUH incurs DME costs because it is a teaching institution. Facts 147.

164. If the indirect costs of teaching hospitals were simply averaged with the costs of non-teaching hospitals, the former would not be adequately reimbursed for the extra costs empirically shown to be associated with their teaching function, as reflected in the issue paper dated October 12, 1984. Facts 151.

165. Based on Medicare results, the defendants acknowledge that a hospital with an intern and resident-per-bed ratio of 0.3 would be expected to have costs about 18% higher than otherwise similar hospitals with an intern and resident-per-bed ratio of 0.0, as reflected in the issue paper dated October 12, 1984. Facts 154.

166. Because it costs more for a teaching hospital to provide care, teaching hospitals would be adversely affected by receiving a uniform DRG payment. Testimony of Gerard Anderson, Transcript at 326, line 25; 327, lines 1-15.

167. As a general proposition, DME costs are legitimate and accepted costs of maintaining a medical school or a teaching hospital. Facts 156.

168. Failure of all payers to pay their share of DME costs would either jeopardize a teaching hospital's teaching program or require that the costs be borne by another source. Facts 157.

169. The MAP papers governing "Teaching Hospitals" and "Direct Medical Education" (Plaintiff's Exhibits 6 and 8), do not contain any rationale or basis-in-fact for the MAP decision not to reimburse the DME costs of out-of-state hospitals. Testimony of Gerard Anderson, Transcript at 331, lines 15-19.

170. Although MAP could have asked for and verified the DME costs for large out-of-state providers, it chose not to. Testimony of James Vertrees, May 4, 5, and 6, 1988 Transcript at 550, lines 12-15. Testimony of Robert Gallagher, Transcript at 605, lines 1-7.

171. MAP stated that it would not pay for educating physicians out-of-state. Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 57, lines 19-24.

172. MAP had no actual data as to the number of physicians who train at WVUH but practice in Pennsylvania. Testimony of David Feinberg, My 4, 5, and 6, 1988 Transcript at 57, line 25; 58, lines 1-4.

V. WVUH Is The Largest Out-of-State Provider of Hospital Services to MAP Medicaid Recipients

173. The Hospital treated more Pennsylvania medicaid recipients than more than one half of the in-state hospitals for the period of July 1, 1985 through June 30, 1986. Facts 160.

174. WVUH provided more care to Pennsylvania medicaid residents than over one half of the in-state hospitals for fiscal year ending June 10, 1985 and fiscal year ending June 30, 1987. Plaintiff's Exhibit 51(A); Testimony of Thomas Manak, Transcript at 252, lines 3-7.

175. The Hospital treated more Pennsylvania medicaid recipients in fiscal year 1985-1986 than any other out-of-state hospital provider. Facts 161.

176. WVUH treated substantially more Pennsylvania medicaid recipients in fiscal year 1984-1985 and fiscal year 1986-1987 than any other out-of-state provider. Plaintiff's Exhibit 55.

177. In fiscal year 1985-1986, 163 out-of-state hospitals provided care to Pennsylvania medicaid recipients. Facts 162.

178. In both fiscal years 1984-1985 and 1985-1986, WVUH treated in excess of 800 Pennsylvania medicaid patient cases. In fiscal year 1986-1987, it treated approximately 730 Pennsylvania medicaid patient cases. The next largest out-of-state provider treated fewer than 160 Pennsylvania medicaid patients. Plaintiff's Exhibit 56.

179. For fiscal years 1984-1985, 1985-1986 and 1986-1987, most out-of-state hospital providers treated fewer than ten Pennsylvania medicaid cases. Plaintiff's Exhibit 56(A). Facts 170.

VI. The Effect of MAP Payment to WVUH

180. Because WVUH treats so many MAP cases, inadequate MAP reimbursement will have substantial financial consequences for the Hospital and will jeopardize its continued ability to care for MAP patients. Testimony of Bernard Westfall, Transcript at 98, lines 2-22. December 28, 1987 Deposition of James Vertrees at 56, lines 4-8; 60, lines 5-22; 61, lines 1-15.

181. If WVUH withdraws from the Pennsylvania medicaid program, it will jeopardize some Pennsylvania medicaid recipients' access to needed health care services. Testimony of

Bernard Westfall, Transcript at 96, lines 14-25; 97, lines 1-18; 98, lines 2-19.

182. The defendants' failure to reimburse the Hospital adequately will also curtail Pennsylvania medicaid recipients' freedom of choice if WVUH is compelled to withdraw from the Pennsylvania medicaid program.

183. On average, MAP reimburses in-state hospitals approximately 95% of the costs they incur in treating Pennsylvania medicaid recipients. In contrast, MAP reimburses WVUH for only approximately 54% of the costs it incurs in treating MAP patients. Testimony of Thomas Manak, Transcript at 663, lines 20-25; 664, lines 1-24.

184. MAP pays an in-state hospital $344.00 more to treat an average case than it pays WVUH to treat an average case. Testimony of Thomas Manak, Transcript at 244, lines 15-19.

185. MAP reimburses WVUH an increasingly lower proportion of WVUH's costs of caring for a Pennsylvania medicaid recipient. Testimony of Thomas Manak, Transcript at 246, lines 14-41. Plaintiffs' [sic] Exhibit 64.

VII. The MAP Appeals System

186. Pursuant to requirements of federal regulation 42 C.F.R. section 446.253(c), the Pennsylvania medicaid agency must provide hospitals with a system by which to appeal. Facts 175.

187. The administrative agency division which adjudicates the appeals is the Department of Public Welfare's Office of Hearings and Appeals (OHA). Testimony of David Feinberg, May 4, 5, and 6, 1988 Transcript at 87, lines 8-10.

188. OHA employs hearing officers, some of them attorneys, to hear appeals, take testimony, admit exhibits, make findings of fact, and determine whether the Pennsylvania Medicaid Agency properly applied its regulations. Defendants' Exhibits 31, 32.

189. The hearing officer recommends a decision to the Director of OHA, who either adopts or rejects the recommendation. Defendants' Exhibit 7. (General Rules of Administrative Practice); 1 Pa. Code, Part II; 55 Pa. Code 1101.

190. Both parties to the administrative appeal, the Office of Medical Assistance and the provider, have the right to request reconsideration from the Secretary should the other party prevail. Id.; 1 Pa. Code 33.61, 35.187(8) and 35.190.

191. Outside of the administrative appeals process, review of the decision of the Director of OHA or the Secretary of DPW may be sought from the judiciary of the Commonwealth of Pennsylvania.

192. The Commonwealth Court is the judicial body in Pennsylvania that is statutorily charged with the duty to review administrative decisions.

193. The administrative hearing officer in the Pennsylvania appeals system would provide no relief to an out-of-state hospital if the out-of-state hospital appealed on the grounds that it should be grouped as if it were an in-state hospital. Facts 177.

194. The administrative hearing officer in the Pennsylvania appeals system would provide no relief to an out-of-state hospital that appeals on the grounds that it should be reimbursed for the Pennsylvania medicaid share of its direct medical education costs. Facts 178.

195. The administrative hearing officer in the Pennsylvania appeals system would provide no relief for an out-of-state hospital

that appeals on the grounds that it should be reimbursed as an in-state hospital for its specific capital costs. Facts 179.

196. The administrative hearing officer in the Pennsylvania appeals system would provide no relief for an out-of-state hospital seeking inclusion of its hospital specific costs during the phase-in of Pennsylvania's prospective payment system as was the case for in-state hospitals. Facts 180.

197. If an out-of-state hospital were to appeal the adequacy of its rate and if the defendants had correctly applied the reimbursement methodology, i.e., the hospital were properly grouped with all other out-of-state hospitals, the hospital received the correct payment for the out-of-state group, and there were no error in the calculations, that out-of-state hospital would not prevail in an administrative appeal before an administrative hearing officer in the Pennsylvania appeals system. Facts 181.

198. No provision of law, including regulations, provides any authority or criteria that governs the Secretary of Public Welfare's grant or denial of relief to a hospital upon the Secretary's reconsideration of an adverse administrative appeals decision. Defendants' Exhibit 2, 3, 4, 5, 15.

VIII. MAP's Findings and Assurances to the Health Care Financing Administration

199. None of the findings and assurances MAP submitted to the Secretary of Health and Human Services (HHS) concerning the Pennsylvania prospective payment system for inpatient care directly references or is applicable to out-of-state hospitals. Defendants' Exhibit 15.

200. Defendants made no assurances to HHS specifically related to the adequacy of MAP reimbursement to out-of-state

hospitals. Testimony of Peter Goodman, Transcript at 525, lines 20-25.

201. The Health Care Financing Administration did not "look behind" MAP's assurances concerning the adequacy of its reimbursement rates, including its payment rates to out-of-state hospitals, nor did it require Pennsylvania to set forth the Commonwealth's specific findings concerning the adequacy of those rates. Testimony of Peter Goodman, Transcript at 531, line 25; 532, lines 1-7.

Discussion

Jurisdiction

Defendants challenge plaintiff's standing to bring this action. In Warth v. Seldin, 422 U.S. 490 (1975), the Supreme Court stated:

> In essence the question of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues. This inquiry involves both constitutional limitations on federal court jurisdiction and prudential considerations on its exercise.... In its constitutional dimension, standing imports justiciability: whether the plaintiff has made out a 'case or controversy' between himself and the defendant within the meaning of Art. III.... A federal court's jurisdiction ... can be invoked only when the plaintiff himself has suffered 'some threatened or actual injury resulting from the putatively illegal action....' [The prudential considerations involve] limits on the class of persons who may invoke the court's decisional and remedial powers.

Id. at 498-99 (citations omitted). In order for a plaintiff to satisfy prudential considerations, he or she generally must be asserting his or her own legal rights and interests, not the rights or interests of third parties. Id. at 499. Furthermore, a plaintiff's injury must be somewhat individualized. "[W]hen the asserted harm is a 'generalized grievance' shared in substantially equal measure by all or a large class of citizens, that harm alone normally does not warrant exercise of jurisdiction." Id.

With regard to the constitutional requirements for standing, defendants' only "argument" is as follows: "[N]othing requires plaintiff to participate in the program. It has no real injury and Article III's requirements have not been met." Defendants' Post-Trial Memorandum at 62. To its credit, WVUH does not respond to this argument. With regard to the prudential considerations, defendants argue that plaintiff, as a provider of medical services, does not have interests within the zones protected by the sections of Title XIX on coverage and protection afforded recipients, neither are plaintiff's interests within the zone protected by the section of Title XIX on payment for hospital services.

The "zone-of-interests" test refers to "the question whether the interest sought to be protected by the complaint is arguably within the zone of interests to be protected or regulated by the statute or constitutional guarantee in question." Association of Data Processing Service Orgs., Inc. v. Camp, 397 U.S. 150, 153 (1970).

The primary beneficiaries of Title XIX are recipients of health care services. However, providers "can properly seek to enforce the reimbursement standards of the Medicaid statute both in the own right and as representatives of Medicaid recipients." Wilmac Corp. v. Heckler, 633 Supp. 1000, 1006 (E.D. Pa. 1986), vacated on other grounds, 811 F.2d 809 (3d Cir. 1987). Because WVUH seeks to enforce the federal standards on reimbursement, it has standing to assert claims under Title XIX. See, e.g., Washington State Health Facilities Ass'n v. State of Washington Dept. of

Social and Health Services, 698 F.2d 964 (9th Cir. 1982) (providers successfully sought injunction to prevent state from enforcing a regulation which deviated from the federally approved state medicaid plan by altering the method of reimbursing nursing care facilities without receiving federal approval); Edgewater Nursing Center, Inc. v. Miller, 678 F.2d 716 (7th Cir. 1982) (nursing home owners unsuccessfully challenged the validity of the cutoff date for determining the year of construction or latest acquisition in Illinois' method of reimbursing capital costs); Troutman v. Cohen, 588 Supp. 590 (E.D. Pa. 1984), aff'd without opinion, 755 F.2d 924 (3d Cir. 1984) (providers unsuccessfully sought injunction against implementation of Pennsylvania's reimbursement regulations).

Defendants also contend the Hospital does not have a cause of action under 42 U.S.C. section 1983 to assert defendants' violations of the Social Security Act. As plaintiff points out, defendants do not challenge the court's jurisdiction to hear a challenge to the state's compliance with federal law; the court has jurisdiction to hear such challenges pursuant to 28 U.S.C. section 1331. Rather, defendants raise a question as to whether the remedy of a section 1983 cause of action is available. 42 U.S.C. section 1983 provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

In 1980, the Supreme Court, rejecting an argument that the phrase "and laws" should be read as limited to civil rights or equal protection laws, stated unequivocally:

> [T]he plain language of the statute [42 U.S.C. 1983] undoubtedly embraces respondents' claim that petitioner violated the Social Security Act.
>
> Even were the language ambiguous, however, any doubt as to its meaning has been resolved by our several cases suggesting, explicitly or implicitly, that the 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law. Rosado v. Wyman, 397 U.S. 397 (1970), for example, 'held that suits in federal court under 1983 are proper to secure compliance with provisions of the Social Security Act on the part of participating States.' Edelman v. Jordan, 415 U.S. 651, 675 (1974).

Maine v. Thiboutot, 448 U.S. 1, 4 (1980).

The Thiboutot Court also discussed the propriety of invoking pendent jurisdiction to decide the Title XIX challenges where constitutional challenges were raised as well. In those cases (cited at 6 in the Thiboutot opinion) "[section] 1983 was necessarily the exclusive statutory cause of action...." Id. at 6. In the case at bar, this court exercises federal question jurisdiction on plaintiff's Fourteenth Amendment challenge of equal protection and can invoke pendent jurisdiction if it so chooses. However, this court is satisfied a Social Security Act cause of action lies under section 1983 whether or not a constitutional challenge exists. The court finds it has jurisdiction to adjudicate this action.

Compliance With Federal Law

The central question in this action is whether defendants satisfy the federal law requirements set forth in 42 U.S.C. section 1396a(a)(13)(A) in reimbursing WVUH for inpatient hospital services provided to Pennsylvania medicaid recipients. Although the court's standard of review of nonadjudicatory agency action is confined to a determination of whether the action is arbitrary or capricious, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971); Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1158 (10th Cir. 1988), "[a] district court can, of course, decide whether federal law has been violated." Mississippi Hosp. Ass'n. v. Heckler, 701 F.2d 511, 516 (5th Cir. 1983). "So long as the specific requirements of the law are met, the Court must defer to the agency's exercise of discretion unless it acts arbitrarily or capriciously." Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891, 896 (E.D. Va. 1985).

The federal law at issue here, 42 U.S.C. section 1396a(a)(13)(A), known as the Boren Amendment, is part of the Omnibus Budget Reconciliation Act of 1980 (OBRA). Congress' purpose in passing the Boren Amendment were twofold: "first, that the states set their own reimbursement rates without stifling and expensive federal oversight of the methodology used; and, second that Medicaid expenses be reduced by allowing the states to develop payment systems which would encourage efficiency." Colorado Health Care Ass'n, 842 F.2d at 1165. The Boren Amendment provides in pertinent part:

> A State plan for medical assistance must - . . . provide - . . . for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) and which, in the case of hospitals, take into account the situation of

> hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and intermediate care facility and periodic audits by the State of such reports; . . . .

42 U.S.C. 1396a(a)(13)(A).

The Health Care Financing Administration (HCFA) charged with the responsibility for administering the Medicare and Medicaid programs, published regulations implementing the Boren Amendment on September 30, 1981. 42 C.F.R. 447.250-447.280. In pertinent part, the regulations require states which participate in the Medicaid program to make findings and submit assurances to HCFA (id. at 447.253(a)(b)) that their inpatient hospital service payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities . . . ." Id. at 447.250(a). Furthermore, states must, in setting their reimbursement rates, "take into account the situation of hospitals which serve a disproportionate number of low income patients . . . ." Id. at 447.253(b) (1)(ii)(A).

It is plaintiff's contention the defendants have not complied with the Boren Amendment or its implementing regulations. WVUH is challenging the legality of Pennsylvania's overall payment system, based upon statutory requirements and upon Pennsylvania's own definition of what should be included in a reasonable rate. One part of the challenge involves the issue of the number and type of low income patients WVUH serves. Approximately thirty-eight percent (38%) of all WVUH admissions are low income persons. This figure includes charity patients, bad debts, and medicaid recipients. Approximately twenty-three percent (23%) of the 38% are medicaid recipients. Out of that 23%, seventeen percent (17%) are West Virginia medicaid recipients and five percent (5%) are Pennsylvania medicaid recipients. The court finds WVUH serves a disproportionate number of low income patients. The statute and implementing regulations are plain and clear in their requirement that states, when setting rates, take into consideration whether a hospital serves a "disproportionate number of low income patients with special needs." Id. Thus, the law provides any reimbursement rate for WVUH must reflect that fact.

When Pennsylvania set its DRG reimbursement rates for out-of-state hospitals, it did not consider whether a hospital served a disproportionate number of low income persons. It merely determined the average DRG reimbursement rate for in-state hospitals and applied that figure across the board to out-of-state hospitals. As an out-of-state hospital, WVUH's low income patient-factor was not considered by DPW when it set the Hospital's rate. WVUH contends Pennsylvania violated federal law because it did not consider the Hospital's low-income-patient-factor.

The defendants argue they are in compliance with federal law because according to their calculations WVUH does not serve a disproportionately high number of low income patients and therefore that factor did not have to be considered in setting the Hospital's rate. The reason the defendants do not consider

WVUH as a hospital with a high low-income-patient factor is because DPW considered only Pennsylvania medicaid recipients in its definition of low income patients. Pennsylvania uses Pennsylvania medicaid volume as a proxy for low income population. While consideration of only Pennsylvania medicaid recipients may be valid for in-state hospital rate setting, (that question is not before the court), it is not valid for out-of-state hospital rate setting. Congress recognized a hospital's costs would be proportionately elevated commensurate with its low income patient population. Members of the Congressional conference on the Boren Amendment "recognize[d] that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and . . . [they were] concerned that a State take into account the special situation that exists in these institutions in developing their rates." H.R. Conf. Rep. No. 97-208, 97th Cong., 1st Sess. 2, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, 1324. Apparently Congress did not intend to distinguish between in-state or out-of-state medicaid patients. Furthermore, low income patients other than medicaid recipients were intended to be included in a state's consideration as well.

A medicaid patient from West Virginia drives up the cost of services the same as a medicaid patient from Pennsylvania. If Pennsylvania's formula for complying with federal law were accepted, it is quite possible a hospital with highly disproportionate numbers of low income patients could be reimbursed at outrageously low rates. A hypothetical situation drafted by plaintiff vividly illustrates the deficiency of Pennsylvania's formula:

[A]ssume the following:

1. A hospital is located where three states converge;

2. The hospital takes 1/3 of its patients from each state;

3. A medicaid volume of 24% is presumed by each state to be indicative of a disproportionate share provider;

4. The hospital has a medicaid volume of 30%, and those medicaid patients come equally from each of the three states (i.e., 1/3 x 30% = 10%).

Under these facts, the hospital is a disproportionate share provider, but if each state were to group the hospital, counting only its 10% share of medicaid patients, the hospital would never receive the more favorable reimbursement treatment Congress intended.

Plaintiff's Post-Trail Reply Memorandum at 28-29.

In order for Pennsylvania to comply with federal law on adequately and reasonably compensating hospitals which serve a disproportionate number of low income patients, it must consider more than Pennsylvania medicaid recipients only. Therefore, the fact that only 5% of WVUH's low income population are Pennsylvania medicaid recipients does not disqualify WVUH from consideration as a disproportionate share provider under federal law. The court finds because defendants did not take the WVUH'S situation vis a vis low income patients into consideration in setting the Hospital's rates, they have violated 42 U.S.C. section 1396a(a)(13)(A) and its implementing regulations 42 C.F.R. sections 447.250447.280.

Defendants also argue they are in compliance with federal law despite not having considered out-of-state hospitals' situations vis a vis low income patients because the federal government approved its plan. DPW submitted assurances to HCFA that its methodology and program met the requirements of the Boren Amendment. The assurances did not included anything regarding

out-of-state hospitals specifically. The assurances were based on information requested from and submitted by in-state hospitals. For instance, one part of the assurances states: "The Department also used all hospitals' most recently filed cost reports for the Medical Assistance Program and the hospitals' last audited per diem rates." Defendants' Exhibit 13. In fact, no cost reports or audited per diem rates were requested from or received from out-of-state hospitals. The assurances read as if all hospitals' individual situations and characteristics were considered by DPW. However, the assurances were based on findings regarding in-state hospitals only. In approving DPW's program, which included the plan for reimbursing out-of-state hospitals, HCFA did not "look behind" the submitted assurances. In other words, the federal government took at face value DPW's assurances that it made findings that its payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities ... [and that DPW took] into account the situation of hospitals which serve a disproportionate number of low income patients...." 42 C.F.R. 447.150, 447.253(b)(l)(ii)(A).

Defendants argue HCFA's approval of DPW's program demonstrates its validity. However, HCFA admits it did not examine DPW's assurances for accuracy or truthfulness or for anything. It merely accepted DPW's statements at face value. This in and of itself would not necessarily undermine DPW's assertion that government approval demonstrates validity, but the fact that the assurances are based only on in-state hospitals does lessen considerably any "weight that HCFA's resultant approval of the plan might otherwise have carried with the Court." Mary Washington Hosp., 435 F.Supp. at 898; see Aitchison v. Berger, 404 F.Supp. 1137, 1148 (S.D.N.Y 1975), aff'd without opinion, 538 F.2d 307 (2d Cir. 1976), cert. denied, 429 U.S. 890 (1976). In fact, the assurances are not based on findings that the plan comports with the statute's requirement of reasonable and adequate compensation and on findings that the plan comports with the statute's requirement that a hospital's low

income-patient-factor be taken into consideration. The court finds because DPW did not comply with the Boren Amendment's implementing regulations, government approval of its plan does not demonstrate the plan's validity.

Another aspect of Pennsylvania's program with which plaintiff takes issue is the system for reimbursement of capital costs. From July 1, 1984 to June 30, 1986, Pennsylvania reimbursed in-state hospitals for the medicaid share of their allowable capital costs. On July 1, 1986, Pennsylvania began a seven year phase-in of a prospective payment system for capital cost reimbursements for in-state hospitals. For out-of-state hospitals, Pennsylvania has reimbursed a fixed amount to cover costs regardless of the actual costs incurred. Pennsylvania has not provided a phase-in period for out-of-state hospitals.

Pennsylvania uses fiscal year 1985 as its base year for the capital reimbursement system. As of the time of trial, WVUH was expected to open its new replacement hospital during 1988. As a result of the opening of the new facility, WVUH will experience a marked increase in its capital costs. Pennsylvania's regulations do not provide an exception to hospitals which replace their facilities, whether they are in or out-of-state hospitals. The base year will be applied to WVUH despite WVUH's recognized need to replace its facility.

In addition to its objections to Pennsylvania's system for capital cost reimbursement and operating cost reimbursement, plaintiff objects to Pennsylvania's decision not to reimburse out-of-state hospitals for their direct medical education (DME) costs. Pennsylvania does not reimburse out-of-state hospitals for any of their DME costs. Largely it is interns' and residents' salaries which account for the bulk of a hospital's DME costs. Residents spend approximately seventy-five percent (75%) of their time administering patient care. Therefore, a reimbursement of DME costs is, in effect, largely a reimbursement for patient care.

Teaching hospitals are virtually always more expensive per DRG than non-teaching hospitals. Pennsylvania recognizes an adjustment in reimbursement is necessary to compensate teaching hospitals for their higher indirect patient care costs. Pennsylvania acknowledges if a teaching hospital did not receive compensation for its DME costs, it could cause serious financial difficulties for the institution. If one payer does not bear its share of DME costs, either other payers will be unfairly burdened with picking up the difference or the existence of the teaching programs could be jeopardized. Concomitant with the increased indirect costs of patient care at a teaching hospital, is the increased quality of care the patients receive. Pennsylvania medicaid recipients get the benefit of this higher quality care but WVUH is not compensated by Pennsylvania for giving it. WVUH asserts Pennsylvania is violating its own definition of adequate and reasonable reimbursement under the OBRA standard. Because Pennsylvania recognizes that its payment of DME costs to its in-state hospitals satisfies the OBRA standards, WVUH argues, that by not making those payments to similarly situated out-of-state hospitals, Pennsylvania is not satisfying the OBRA standards.

The reason defendants offer for not reimbursing out-of-state hospitals is they do not wish to finance the training of non-Pennsylvania physicians. However, not all WVUH residents practice in West Virginia. Approximately seven percent (7%) of them practice in Pennsylvania. Also, not all residents trained in Pennsylvania will practice there. Thus, Pennsylvania does help finance the training of non-Pennsylvania physicians. In addition to Pennsylvania medicaid recipients receiving the benefits of a higher quality of care, and in addition to Pennsylvania benefitting from having some of its physicians trained at WVUH, Pennsylvania doctors also benefit from WVUH's teaching status by using the Hospital's resources and expertise through the Medical Access Referral System.

Reasonableness and Adequacy

Although plaintiff attacks the validity of each of the components of defendants' out-of-state reimbursement system, it is the validity of the system as a whole and the resultant total rate of reimbursement which is important. E.g., Colorado Health Care Ass'n v. Colorado Dept. of Social Services, 842 F.2d 1158, 1167 (10th Cir. 1988). For instance, it is not controlling whether Pennsylvania provides a phase-in period on capital costs reimbursement or whether it engaged in a grouping analysis for out-of-state hospitals. In the Colorado Health Care Ass'n case, the court considered a challenge to the Colorado Department of Social Services' decision to suspend an incentive payment available in the state's reimbursement system. The challengers argued dropping the incentive payment violated the Boren Amendment. The court disagreed.

> It is the resulting overall payment which is evaluated for statutory compliance. See Wisconsin v. Reivitz, 733 F.2d 1226, 1233 (7th Cir. 1984) (price medicaid reimbursement rate is not, per se, the only reasonable and adequate rate); accord Illinois Council on Long Term Care v. Miller, 579 F.Supp. 1140, 1147 (N.D.E.D.Ill. 1983). Reasonableness has been characterized as a zone, not a pinpoint.

Id.

The zone of reasonableness has been construed "as a zone or range in which a State may consider the relevant factors and data and determine a valid reimbursement which is reasonable and adequate. The state must articulate a 'rational connection between the facts found and the choice made.'" Colorado Health Care Ass'n, 842 F.2d at 1167 (quoting Baltimore Gas & Electric Co. v. Natural Resources Defense Council, Inc., 462 U.S. 87, 105 (1983)).

To determine its methodology and rate reimbursement to in-state hospitals, Pennsylvania requested and received a very large amount of information from those hospitals. Pennsylvania confirmed the information, broke it down, studied it, massaged it, and used it to create a detailed, sophisticated methodology of reimbursement. The purpose behind the methodology was to create a system which would be responsive to the situational realities of the in-state hospitals, while keeping within conservative budgetary limits. Achieving this purpose would satisfy the goals of the Boren Amendment "that medicaid expenses be reduced by allowing the states to develop payment systems which would encourage efficiency." Colorado Health Care Ass'n, 842 F.2d at 1165. Furthermore, achieving this purpose would also satisfy the statutory and regulatory requirements of the Boren Amendment by reimbursing hospitals reasonably and adequately for their costs in treating medicaid patients.

Pennsylvania's approach to developing a methodology for out-of-state hospitals contrasts sharply with its approach to developing one for in-state hospitals. It admits it did not in any way whatsoever attempt to design a methodology which would be even remotely related to the situational realities of out-of-state hospitals. For operating costs reimbursements, Pennsylvania took the average payment to in-state hospitals and blindly applied it to each out-of-state hospital. For capital costs reimbursements, Pennsylvania determined a base year and a flat rate and blindly applied it to each out-of-state hospital. For direct medical education costs reimbursement, Pennsylvania cut-out payment altogether.

In addition, as has been discussed at length, supra, defendants have not complied with the statute's directive to consider the low income patient status of the Hospital, nor has Pennsylvania complied with the implementing regulations' requirement that the assurances made to HCFA be based on findings that a payment is adequate and reasonable. The

defendants did not base their decisions on anything pertinent regarding the out-of-state hospitals themselves.

Defendants allege administrative resource and self-imposed time constraints dictated their handling of out-of-state hospitals. The court is not insensitive to the state's budgetary limitations. Here, budgetary limitations meant only a certain number of people were available to work on developing the prospective payment system. These budgetary and resultant personnel constraints can be considered by the state as a factor in developing the system, "so long as the result complies with the federal requirements for a reasonable and adequate payment." Colorado Health Care Ass'n, 842 F.2d at 1168. In short, budgetary constraints will not excuse a state's failure to comply with federal law. Wisconsin Hospital Ass'n v. Reivitz, 733 F.2d 1226, 1236 (7th Cir. 1984); Friedman v. Perales, 668 F.Supp. 216, 221 (S.D.N.Y. 1987), aff'd, 841 F.2d 47 (2d Cir. 1988). The defendants admit they did not treat the issue of out-of-state hospital methodology and reimbursement as a substantive issue. It was for them merely a technical issue.

It is certain defendants did not base their decisions on out-of-state hospitals on any relevant data. They did not attempt to test their decision against the requirements of the federal law. In essence, they assumed, without any basis-in-fact, their decision was valid under the federal law. The court finds, "[s]uch intuitional forms of decision making, completely opaque to judicial review, fall somewhere on the distant side of arbitrary." Central Florida Enterprises, Inc. v. Federal Communications Comm'n, 598 F.2d 37, 50 (D.C.Cir. 1978), cert. denied, 460 U.S. 1048 (1983). The state has failed to articulate a rational connection, or any connection, between the situational realities of out-of-state hospitals and the decision to reimburse them as it chose. Therefore, the court finds the decision made by Pennsylvania on how to reimburse out-of-state hospitals and at what rate was arbitrary and capricious. In its totality, Pennsylvania's prospective payment system for out-of-state

hospitals violates federal law. The payments to WVUH are not reasonable and adequate: the payments do not reflect WVUH's high low income patient population; the payments do not compensate WVUH for Pennsylvania medicaid's share of the Hospital's DME costs; the payments will not fairly cover Pennsylvania's medicaid share of WVUH's capital costs; and the DRG payment rate is insufficient to meet the operating costs incurred by this "efficiently and economically operated" facility[2].

WVUH is being harmed by receiving less than adequate payment from Pennsylvania. Had the Hospital been treated as a similarly situated hospital in Pennsylvania, and had the defendants complied with federal law regarding consideration of a hospital's low income patient population, WVUH would have received approximately $2.3 million more from Pennsylvania than it has received under the prospective payment system. On average, an in-state hospital is reimbursed for approximately 95% of its costs in treating a Pennsylvania medicaid recipient. WVUH is reimbursed for approximately 54% of its costs in treating a Pennsylvania medicaid recipient. Either in-state hospitals are receiving a huge windfall, or WVUH is receiving far less than it is entitled to under the federal law.

As noted in the findings of facts, the prospective payment system which is a DRG payment-based system creates cases which are "winners" and "losers." A "winner" is a case for which a hospital is paid more than what its charges are in that case. A "loser" is a case for which a hospital is paid less than what its charges are in that case. The prospective payment system was designed to balance the incidents of winners and losers to ensure no hospital is over or under compensated in the long-run. That is how it works for in-state hospitals. It does not work that way for

---

2 It should be noted defendants have not alleged WVUH is not an "efficiently and economically operated" facility.

out-of-state hospitals. Out-of-state hospitals never get winners. This is because they are paid either the DRG payment or their actual charges -- whichever is less. Without a balance of winners and losers, a hospital will surely be underpaid in the long-run.

WVUH is being harmed by its treatment under Pennsylvania's payment system. The inadequacy of reimbursement raises serious questions about WVUH's ability to provide care to Pennsylvania medicaid recipients. The Hospital cannot continue indefinitely to sustain the losses imposed on it under the current reimbursement system. The defendants' own expert testified that although a prospective payment system which relied exclusively on a statewide average may be a desirable ultimate goal, imposing such a system suddenly, would be "dangerous." He testified "[i]t would bankrupt them [the hospitals] potentially .... [T]he teaching hospitals in particular have extremely high costs." Vertrees Deposition at 40, lines 13-15. WVUH cannot continue indefinitely to provide the level of services and care it not provides to Pennsylvania medicaid recipients if it continues to receive inadequate and unreasonable reimbursement from Pennsylvania. Testimony of Bernard Westfall, Transcript at 96-98.

WVUH is by far Pennsylvania's most important out-of-state provider. Although it may only account for one percent (1%) of Pennsylvania's provider budget, it treats more Pennsylvania medicaid recipients than half the hospitals in Pennsylvania. Forcing the Hospital to limit or compromise the quality of care or services it provides to Pennsylvania medicaid recipients is in contravention of the Boren Amendment. The "ultimate touchstone" of the Boren Amendment is whether

> a reimbursement policy will alter the availability of or quality of care to be provided.... 46 Fed. Reg. 47970; see Mary Washington Hospital, Inc. v. Fisher, ... 635 F.Supp. at 901-904 (Congress added reasonable access constraint to prevent states from lowering reimbursement rates so much that a dangerous number of hospitals might withdraw from the program).

Friedman v. Perales, 668 F.Supp. at 225. The reimbursement system, if not altered, will ultimately have a measurable negative impact on Pennsylvania medicaid recipients because their ready access to quality care will be impaired. This is another reason why the overall system for out-of-state hospitals is violative of the federal law.

Fourteenth Amendment

Another question before the court is whether Pennsylvania's disparate treatment constitutes unconstitutional discrimination in violation of WVUH's equal protection rights under the Fourteenth Amendment. The state has developed a payment methodology in which it classifies hospitals and bases reimbursements on hospitals' classifications. The method used by the state has resulted in plaintiff being placed in a class in which it receives a considerably lower reimbursement than other hospitals similarly situated but within Pennsylvania's borders.

The court applies a "traditional" equal protection analysis because suspect classifications such as race, religion or national origin are not involved here. "Under 'traditional' equal protection analysis, a legislative classification must be sustained unless it is 'patently arbitrary' and bears no rational relationship to a legitimate governmental interest." Frontiero v. Richardson, 411 U.S. 677, 683 (1973)(citing Jefferson v. Hackney, 406 U.S. 535, 546 (1972)); Richardson v. Belcher, 404 U.S. 78, 81 (1971); Flemming v. Nestor, 363 U.S. 603, 611 (1960); McGowan v. Maryland, 366 U.S. 420, 426 (1961); Dandridge v. Williams, 397 U.S. 471, 485 (1970). Whether defendants' classifications are unconstitutional turns on the question of reasonableness.

> In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some 'reasonable basis,' it does not offend the Constitution simply because the classification 'is not made with mathematical nicety or because in practice it results in some inequity.'

Dandridge v. Williams, 397 U.S. at 485 (quoting Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 68 (1911)).

In cases involving economics and social welfare wherein classifications and resultant "imbalanced" treatment occur, the United States Supreme Court looks for links between legitimate governmental interests and the classifications. E.g. Dandridge v. Williams, supra (State regulation placing a maximum ceiling on benefits in the Aid to Families with Dependant Children (AFDC) program was challenged unsuccessfully by large family recipients. Court found the regulation free from invidious discrimination and found it rationally related to the "State's legitimate interest in encouraging employment and in avoiding discrimination between welfare families and the families of working poor." Id. at 486.); Jefferson v. Hackney, 406 U.S. 535 (1972) (State's decision to provide somewhat lower welfare benefits to AFDC recipients than to the aged and infirm was not invidious or irrational because it is not unreasonable for a state to conclude "that the aged and infirm are the least able of the categorical grant recipients to bear the hardships of an inadequate standard of living.... [I]t is not irrational for the State to believe that the young are more adaptable than the sick and elderly...." Id. at 549.); Richardson v. Belcher, 404 U.S. 78 (1971)(Recipient of federal disability benefits challenged classification wherein his benefits were reduced as a result of his receipt of state workmen's compensation benefits. The Court found Congress' goals of encouraging able workers to return to work and forestalling the erosion of workmen's compensation programs were legitimate,

and the challenged classification was rationally related to the achievement of those goals.)

In the case at bar, defendants have not clearly articulated just what their interest are. This makes the task of evaluating the legitimacy of the state's interests difficult. Further, defendants have not coherently argued the link between the classifications of in-state versus out-of-state and the achievement of state interest (whatever they may be). Rather, they defend their decision by pointing out perceived differences in the classes and the administrative difficulties they would experience if out-of-state hospitals were classified under the in-state hospital grouping system and paid under the in-state hospital methodology.

Defendants argue it is reasonable to classify out-of-state hospitals differently based on that characteristic of being an out-of-state hospital alone because: "they are eligible for payment only in limited circumstances (42 C.F.R. 431.52(b)), provide services infrequently, do not file cost reports, are administered by other states, are often not enrolled as providers until after services are rendered, and are not subject to the same documentation and auditing requirements as in-state providers." Defendants' Post-Trial Memorandum at 32. None of defendants' proffered reasons provides a rational basis for the state's discriminatory practice.

Defendants' assertion 42 C.F.R. section 431.52 provides a basis for treating out-of-state hospitals differently is not supported. The regulation is not directed towards the treatment of hospitals but towards the treatment of medicaid recipients. The regulation merely enumerates the instances and circumstances under which Pennsylvania residents may receive medicaid benefits when the residents are absent from the state. The argument on out-of-state hospitals providing services infrequently is based on an inaccurate analysis. While the statement may be true for some, or even many out-of-state hospitals, it is not at all true for WVUH. As noted previously,

plaintiff treats more Pennsylvania medicaid recipients than half of Pennsylvania's hospitals. As to out-of-state hospitals not filing cost reports, defendants do not request cost reports. There is nothing in the record to suggest plaintiff and other out-of-state hospitals would not file cost-reports if requested by defendants. Next, the fact that out-of-state hospitals are administered by other states does not explain why they should receive different reimbursement rates or be treated differently as to DME costs or capital costs. That out-of-state hospitals are often not enrolled as providers until after services are rendered does not explain why those hospitals which are enrolled receive disparate treatment. Finally, defendants' asserted rationale that disparate treatment is warranted because out-of-state hospitals are not subject to the same documentation and auditing requirements fails to provide a link because, again, there is nothing in the record to suggest out-of-state providers would not supply appropriate documentation, if asked to do so, and would not subject themselves to audits, if asked to do so. Indeed, Pennsylvania could audit 75-100 more hospitals each year without increasing its audit staff.

After listing their "justification" for the disparate treatment, the defendants offer what appear to be interests. They state:

> DPW reasonably determine [sic] that certain incentives for growth, quality of care, and availability, e.g., special payments for medical education costs, were not warranted for out-of-state facilities because the return on such incentive payments was not as significant as from such payments to in-state hospitals.[3]

3 The court has already discussed (see pages 45-46 of the memorandum) the irrationality of DPW's reasoning regarding payment of DME costs.

There is no evidence in the record to support a finding these "interests" were thought of, let alone articulated, during the decision making process. Even the court's use of the term "decision making process" rings untrue in light of the manner in which the decisions regarding out-of-state hospitals were made. DPW did not "reasonably determine" anything regarding out-of-state hospitals. Defendants did not attempt to acquire information on out-of-state hospitals. They did not inquire about which, if any, out-of-state hospitals were frequent providers. They did not inquire as to what impact their decision would have on the hospitals. In its post-trial reply brief at page 57, plaintiff provides a telling summary of how and why decisions on out-of state hospitals were arrived at. Citing and quoting from Mr. Debrunner's testimony, plaintiff explains:

> [O]ut-of-state hospitals reimbursement had no perceived political implications, Transcript at 498, lines 10-15; ... no empirical studies were done to determine how to reimburse out-of-state hospitals, Transcript at 498, lines 16-19; ... no one was complaining, Transcript at 498, lines 23-25; and ... 'why fix what ain't broke.' transcript at 449, lines 7-9.

The court finds defendants have not articulated a rational connection between their asserted interest and the classifications of in-state versus out-of-state hospitals. Defendants' decision to classify out-of-state hospitals in the manner they did was arbitrary, not related to legitimate state interest and the classification has resulted in invidious discrimination. Defendants have violated plaintiff's Fourteenth Amendment rights.

Administrative Appeals System

Federal law requires states participating in the medicaid program to have an appeals process whereby payment rates can be

reviewed. 42 U.S. C. 1396(a)(37); 42 C.F.R. 447.253(c). The federal regulation states:

> Provider appeals. The medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. 447.253(c). Plaintiff contends defendants' appeals system is legally inadequate because it is undisputed that were WVUH to appeal its payment rate, it absolutely could not obtain relief if the out-of-state methodology had been correctly applied. Pennsylvania defends the validity of its appeals process asserting DPW has the authority to hear and determine challenges to the validity and constitutionality of its regulations.

When Congress revised the medicaid statutes it recognized the importance of an adequate appeals process. Early on, HCVA expressed its concern regarding the appealability of individual facilities' rates.

> The revised regulations require each State agency to develop an appeals procedure that allows a provider to submit evidence to the agency and seek prompt administrative review of its payment rate. We believe the appeals requirement described above is needed because individual facility rates will not receive Federal review under the revised regulations.
>
> We believe that individual facilities must be given some opportunity to request review and adjustment of their rates.

46 Fed. Reg. 47968-47969 (September 30, 1981)(emphasis added). After receiving invited comments on appeals regulations, HCVA iterated its position on reviewable rates. Displaying confidence in the states' abilities to recognize the need for rate reviewability and to promulgate adequate appeals systems, HCVA declined to write-into the regulations provisions on retroactive or prospective adjustments. It stated: "We believe that fair and reasonable rate adjustments are implicit in an appeals process and see no need for a prescriptive Federal requirement." 48 Fed. Reg. 56052 (December 19, 1983). The plain language of the regulation and the pertinent legislative history make it clear legally sufficient appeals systems provide for individual facilities to meaningfully challenge their rates. To the court, this means a facility can have the propriety of its rate reviewed, not merely the accuracy of the application of the methodology employed to arrive at the rate.

The plaintiff in Mary Washington Hosp., Inc. v. Fisher, 635 F.Supp. 891 (E.D.Va. 1985) challenged Virginia's appeals process. The parallels of the Virginia system to the Pennsylvania system are so strong that extensive quoting from that case is appropriate here. Discussing the Virginia appeals provision, the court stated:

> This appeals provision states little more than the hospitals can appeal the application of the principles of reimbursement but they cannot appeal the principles of reimbursement themselves.... [T]his means that a hospital could appeal only on, e.g., whether it was properly categorized as ... rural instead of urban. Evidence that a particular hospital's costs were high for its peer group because of special, necessary, and expensive services which it alone offered could not justify any relief, even partial, from the general rate under ... [Virginia's] interpretation. Likewise evidence that a hospital's costs were higher than those of its peer group for reasons beyond its control would not get a hospital

> any additional reimbursement under Virginia's system, even if that hospital's participation in the Medicaid program was crucial to ensure certain Medicaid recipients "reasonable access" to hospital services.
>
> The Court is satisfied that Virginia's appeals provision, as interpreted, is unreasonably and arbitrarily narrow.

Id. at 904. This court agrees with the Mary Washington court in that

> the more general the rate-setting system is, the stronger the need for some appropriate method of accommodating particular situations that the general rules do not adequately address.... If, ... a state fixed a single reimbursement rate across the state, there would almost certainly be a need for a broader form of appeal or exception process that would allow individual hospitals relief from the general rule.

Id. at 903.

The observation regarding a single reimbursement rate and the concomitant need for a broad form of appeal is as accurate in a situation where the single rate is set for out-of-state hospitals as it is where the single rate is set for in-state hospitals. The impropriety of the single rate should be open to challenge by individual providers. In the instant case, defendants admit WVUH cannot appeal the fact of its rate. It can only appeal the application of the methodology. For all practical purposes, the only question entertained on appeal would be "was WVUH properly categorized as an out-of-state hospital rather than an in-state hospital." That question would be answered in the affirmative, thus effectively ending all inquiry into WVUH's rate. The court finds Pennsylvania's appeals system legally insufficient

because a provider with a facially bona fide rate challenge cannot obtain a meaningful review. If an appeals systems provides only that a rate adjustment challenge begin and end with an inquiry into whether the numbers were correctly crunched and whether the "i's" were dotted and "t's" crossed, that appeals system does not meet the federal standards.

The defendants argue the appeals system is legally sufficient because the agency is empowered to rule on the validity and constitutionality of its own regulations. See the authority cited at 34-35 of Defendant's Post-Trial Memorandum. The court agrees, as a general proposition, Pennsylvania state agencies are so empowered; however, as a practical matter such empowerment is ineffective in the instant matter. The state's position regarding the constitutionality of its prospective payment system and its administrative appeals process is quite clear: both fully comport with federal regulations and are constitutionally sound. This court will not force a provider to take its challenges to an agency when the agency's adjudication of the challenges is a foregone conclusion. See Delaware Valley Convalescent Center v. Beal, 488 Pa. 292, 412 A.2d 514 (1980)(where nothing in the record suggests a provider would not be afforded a meaningful administrative agency review, exhaustion is requested as a prerequisite to judicial review).

Defendants have admitted were WVUH to appeal its rate, the rate itself would not be adjusted. Only the application of the formula would be reviewed. This means WVUH "can appeal the application of the principals of reimbursement but [it] ... cannot appeal the principals of reimbursement themselves...." Mary Washington at 904. As discussed above, this is inadequate under the federal law.

Lastly, defendants point out the Secretary of Public Welfare has the authority to invalidate, waive or grant exceptions to any of the regulations. The statutory authority for this purported power is 1 Pennsylvania Code section 33.61, 35.18,

35.187(8), and 35.190. After carefully reading these code sections, the court finds they do not address the Secretary's authority to waive regulations or grant exceptions to them. They serve merely as a "how to" for aggrieved parties. 1 Pennsylvania Code section 33.61 concerns how to get a waiver of the formal requirements of the appeals process. It has nothing to do with obtaining a waiver of a substantive regulation. Next, section 35.18 delineates the appropriate content and form for petitions for waivers. Again, nothing in this section relates to the power of the Secretary to grant petitions. Section 35.187(8) speaks to the authority of presiding officers to certify questions to the agency head for disposition by the agency head. Finally, section 35.190 concerns the procedure whereby an aggrieved party can appeal the rulings of presiding officers: subsection (a) discusses the propriety of interlocutory appeals to the agency head during the pendency of hearings; subsection (b) discusses the requirements for "offers of proof" made in connection with an objection to a ruling on proffered oral testimony; and subsection (c) discusses the significance of the agency head's timetable for rendering decisions. Again, nothing in this section bears on the Secretary's purported authority to waive substantive regulations.

The case law cited in support of defendants' contention on the Secretary's authority is almost as unpersuasive as the statutory support. In Stanley v. Commonwealth, Department of Public Welfare, 535 A.2d 674 (Pa.Commw. 1987), the Secretary had discretion to approve payment of an infant's hospital bill where the parents failed to supply information substantiating eligibility. In Quincy United Methodist v. Commonwealth, Department of Public Welfare, 109 Pa.Commw. 230, 530 A.2d 1026 (1987) the Secretary had discretion to permit an untimely appeal of an audit report. From the authority cited by defendants, the court cannot find the Secretary's power, whatever the extent of it may be, is a substitute for an otherwise invalid appeals process. The cases cited by defendants involve situations wherein the Secretary is waiving mere procedural requirements. In the Stanley case, the Secretary had the discretion to waive the requirement that certain

information be submitted before benefits could be granted. In the Quincy case, the Secretary had the power to waive the time limitation for filing an appeal. Neither of these cases supports the contention the Secretary can waive substantive regulations. WVUH is not requesting a simple time extension or an exception from a technical formality. Rather, it requests a total exemption from the state's entire medicaid reimbursement methodology. It has not been demonstrated the Secretary has the power to grant such a request. The seemingly unfettered discretion of a state official cannot serve as a substitute for a full-blown, meaningful appeals process.

Scope of Relief

In this action plaintiff sues state officials in their official capacities. Thus the state, as the real party in interest, can invoke its sovereign immunity protection under the Eleventh Amendment.[4] Pennhurst State School & Hospital v. Halderman, 465 U.S. 89, 101 (1984). Defendants have raised a sovereign immunity defense to all retrospective relief demanded by plaintiff.

The law on sovereign immunity is not carved in stone. Since the first exception to the Eleventh Amendment was established in 1908, (Ex Parte Young, 209 U.S. 123 (1908)), courts have struggled to define the Amendment's natural boundaries. In Ex Parte Young, supra, the Court held the protection of the Amendment was unavailable in a suit challenging the

---

4 The Eleventh Amendment to the United States Constitution provides:

The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

constitutionality of a state official's enforcement of a state law. The sole remedy in Young was prospective relief.

The distinction between retrospective and prospective relief has blurred with courts' attempts to provide meaningful equitable relief to wronged parties. See, e.g., Milliken v. Bradley, 433 U.S. 267 (1977) (Court upheld district court's order requiring state defendants to pay one-half of the costs attributable to remedial measures aimed at curing the effects of prior school segregation); Clark v. Cohen, 794 F.2d 79 (3d Cir. 1986), cert. denied, 479 U.S. 962 (1986) (appeals court upheld district court's order requiring state to provide program of services directed at remedying harm incurred by woman wrongfully confined to a mental institution). Although there is no bright line distinction, the differences between the two types of relief are discernible. In Brown v. Eichler, 664 F.Supp. 865 (D.Del. 1987), the court efficiently summarizes the boundaries of appropriate remedies allowable under the Eleventh Amendment.

> The distinction between retrospective and prospective relief depends not on when the relief is awarded but on when the violation for which relief is awarded occurs. All relief, whether damages or injunctive, must be given in the future. If that relief is aimed at remedying a past harm, it is considered retrospective relief and barred by the Eleventh Amendment. By contrast, a remedy aimed at curing a present violation in the future is considered prospective relief. Last, direct awards of monetary relief against the State are forbidden, while awards with only an ancillary effect on the State treasury are permissible.

Id. at 872-73 (citing Quern v. Jordan, 440 U.S. 332 (1979)).

Assuming the court orders defendants to develop a new appeals system, WVUH asks this court to order defendants to

permit the Hospital to appeal its fiscal years 1984 and 1985 reimbursements under the new appeals system. This request is nearly identical to that of the plaintiffs in Brown. In that case, the plaintiffs challenged Delaware's federal tax refund intercept program. The court found state procedures violated the due process rights of obligated parents and non-obligated spouses of obligated parents due to a failure to inform them of potential defenses. The plaintiffs requested the court to enjoin the state to re-do the past procedures for the 1983 and 1984 intercept of refund checks using the new court-ordered procedures. The 1983 intercept occurred before the action was commenced; the 1984 intercept occurred afterwards. The court addressed the two intercepts separately. The court's framing of the sovereign immunity issue regarding the 1983 intercept works quite well for the framing of the sovereign immunity issue in the instant action for the fiscal years 1984 and 1985. The Brown court stated the issue thusly:

> The question for this Court with respect to the 1983 intercept is whether an injunction aimed at remedying a past due process violation that only has an ancillary effect on the state treasury -- only new hearings will be required; there will not be a direct award of money -- can be issued in the context of a case where there is an ongoing state official's violation of federal law, but the injunction for new hearings for the past is not needed to remedy the situation for the future.

Id. at 873 (footnote omitted).

In the instant action, the court is concerned with an on-going state official's violation of federal law; the requested injunction would have only an ancillary effect on the state treasury; and the injunction would be aimed at remedying a past violation. The unusual combination of factors involved in the question of relief in this situation was not lost on the Brown court.

That court noted: "This question is a somewhat anomalous one because the relief requested is neither retrospective monetary relief nor prospective injunctive relief. Instead, it is retrospective, injunctive relief." Id.

Two Supreme Court cases, Milliken v. Bradley, supra, and Quern v. Jordan, 440 U.S. 332 (1979) contained some element of retrospective relief and bear examination. In the school segregation case, Milliken, the relief was aimed at eliminating

> the continuing effects of past misconduct. Reading and speech deficiencies cannot be eliminated by judicial fiat; they will require time, patience, and the skills of specially trained teachers. That the programs are also 'compensatory' in nature does not change the fact that they are part of a plan that operates prospectively to bring about the delayed benefits of a unitary school system.

422 U.S. at 290. Although the violation was antecedent, it caused deficiencies in the students which, if not remedied, would continue to harm them far into the future.

In the Quern case, the Court held a federal court could order state officials to send a notice to victorious plaintiff class members informing them, "that their federal suit is at an end, that the federal court can provide them with no further relief, and that there are existing state administrative procedures which they may wish to pursue." 440 U.S. at 332. The Court found such a notice would not lead "inexorably" to the state paying past benefits. The chain of causation between the sending of the notice and the payment of benefits retroactively

> is by no means unbroken; it contains numerous missing links, which can be supplied, if at all, only by the State and members of the plaintiff class and not by a federal court. The notice ... simply apprises

> plaintiff class members of the existence of whatever administrative procedures may already be available under state law by which they may receive a determination of eligibility for past benefits.... [W]hether or not the class member will receive retroactive benefits rests entirely with the State, its agencies, courts, and legislature, not with the federal court.

Id. at 347-48 (footnote omitted). The court viewed the notice and its possible retrospective element as ancillary to the prospective relief already ordered. In a later Supreme Court case, Green v. Mansour, 474 U.S. 64 (1985), the Court characterized the sending of the Quern notices as a "mere case-management device." Id. at 71.

The distinctions between the instant action and Milliken, Quern, and the Third Circuit's Clark (discussed briefly supra at pages 62-63 of this memorandum), are determinative on the issue of sovereign immunity. In Milliken and Clark it was determined the plaintiffs would continue to suffer harm because of violations visited upon them in the past by their respective state officials. The relief in those cases was aimed at eradicating those continuing harmful effects; the relief was not aimed at compensating those plaintiffs for harm done and past. In the instant action, the only continuing harm is the unrecovered loss of money. While the court is not insensitive to WVUH's sizeable monetary loss, the court cannot order relief which will almost certainly result in the recovery of money for the sole purpose of recovering money. The court cannot order the plaintiff be made whole if it is money only which it needs to be made so. Like the violations in Brown, the violations in the case at bar are "discrete for each year." Brown, 644 F.Supp. at 874. There is a continuing effect on the Hospital caused by its having been denied money it was entitled to, but the nature of that harm is not such that it will affect the future of the institution in a fundamental way. The court has recognized WVUH cannot continue to sustain the level

of losses it has been sustaining and still be certain of providing the services it does presently. However, there is nothing in the record which informs the court that recovery of the alleged 2.3 million dollars owed it for the fiscal years 1984 and 1985 are crucial to the Hospital's future viability.

The Quern situation appears to be somewhat closer to plaintiff's than the other cases discussed, but it too is meaningfully distinguishable. In Quern, the approved notice gave no more to the class members "than what they would have gathered by sitting in the courtroom.[...]" 440 U.S. at 349 (quoting Jordan v. Trainor, 563 F.2d 873, 878 (7th Cir. 1977), aff'd sub nom., Quern v. Jordan, supra). The court approved only of plaintiffs being notified of a possibility of consideration for past benefits. It was not at all certain the sending of the notice would have any effect on the state's treasury (beyond the cost of sending it -- which was not objected to by the state). In the instant matter there is no class; there is only one plaintiff. WVUH need not be specially notified of the status of its federal court case, as did the Quern plaintiffs. The Quern notice advised plaintiffs of the existence of the administrative process available to them generally. It was not directed specifically to facilitate awards of past benefits. That past benefits might be available was ancillary to the prospective relief regarding availability of future benefits. In contrast to this is WVUH's request which focuses only on the collection of money allegedly owed for past violations. There is no prospective component to what the Hospital requests. Its requested relief goes only to compensation for past violations. The court is aware that even if it were to order the state to permit WVUH to appeal its fiscal years 1984 and 1985 rates under a new system, a system developed in keeping with this memorandum, there is no guarantee the Hospital would collect a specific dollar amount. However, assuming the development of a valid, constitutional methodology, reimbursement rate, and appeals system, WVUH would undoubtedly qualify for some compensation.

Finally, as the Brown court observed,

> [1]ying at the core of the prospective-retrospective distinction in the Eleventh Amendment jurisprudence is the inherent tension between state sovereign immunity and the Federal Supremacy Clause.[12] [5] '[T]he availability of prospective relief of the sort awarded in Ex Parte Young gives life to the Supremacy Clause.... But compensatory or deterrence interests are insufficient to overcome the dictates of the Eleventh Amendment.' ...[Green v. Mansour, 474 U.S. 64, 68 (1985).] A balance between the constitutional provisions has been struck at the point of the retrospective-prospective distinction. When the purpose of a remedy is only to compensate for the past violations, the Eleventh Amendment takes precedence over the Supremacy Clause.

Brown, 664 F.Supp. at 875 (emphasis added). The court finds the sole purpose for WVUH's requested relief of ordering the state to entertain an appeal for the years 1984 and 1985 is to compensate for past violations. The Eleventh Amendment bars such compensation.

The court finds, however, the Eleventh Amendment does not bar an injunction ordering the state to permit the Hospital to appeal the reimbursements it received from the date the complaint was filed. Brown, 664 F.Supp. at 876; Smith v. Onondaga County Support Collection Unit, 619 F.Supp. 825 (N.D.N.Y. 1985). Although such an appeal is aimed at curing past reimbursement deficiencies, this relief, when first requested by

---

5 "12. 'This Constitution, and the Laws of the United States ... shall be the supreme Law of the Land.' U.S. Const. art. VI [cl.2.]"

WVUH, was prospective. Ordering the state to conduct appeal hearings for the period of time after the complaint was filed is a proper ordering of prospective, injunctive relief. Brown, 664 F.Supp. at 876. However, this court cannot order a recovery of money damages. Id. at 876 n.13.

Conclusion

The court finds Pennsylvania's prospective medicaid program as it applies to WVUH does not comply with federal law; through its treatment under the program, WVUH's Fourteenth Amendment equal protection rights have been violated; and the administrative appeals system, as it applies to WVUH, is inadequate and does not comply with federal law. An appropriate order will issue.

Sylvia H. Rambo
United States District Judge

Dated: November 30, 1988

ORDER

In accordance with the accompanying memorandum, **IT IS HEREBY ORDERED THAT:**

1) the court declares the Commonwealth of Pennsylvania's medicaid prospective payment system as it applies to West Virginia University Hospital is violative of federal law;

2) the court declares the Commonwealth of Pennsylvania's medicaid administrative appeals system as it applies to West Virginia University Hospital is violative of federal law;

3) the court declares plaintiff's Fourteenth Amendment equal protection rights have been violated as a result of its treatment under the Commonwealth of Pennsylvania's medicaid prospective payment system;

4) defendants shall, within ninety (90) days of the entry of judgment, formulate (and seek approval of same from the appropriate federal authority) a methodology and a medicaid prospective payment system for West Virginia University Hospital consistent with and in conformity with federal law as discussed in the accompanying memorandum;

5) defendants shall, within ninety (90) days of the entry of judgment, formulate (and seek approval of same from the appropriate federal authority) an adequate and meaningful (as those terms are used in the accompanying memorandum) medicaid administrative appeals or exception system for West Virginia University Hospital;

6) defendants shall permit West Virginia University Hospital to utilize the new appeals or exception system to challenge its reimbursements from the date this action was commenced;

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

WEST VIRGINIA UNIVERSITY HOSPITALS, INC.,	)	
Plaintiff,	)	
	)	CIVIL ACTION NO. 86-0955
	)	(Judge Rambo)
v.	)	
ROBERT CASEY, ET AL.,	)	
Defendants.	)	

MEMORANDUM

Background

On November 30, 1988 this court granted plaintiff's request for attorney's fees pursuant to 42 U.S.C. Section 1988 (Section 1988) and ordered the parties to submit a joint proposal on the fees amount. On December 14, 1988 the parties submitted a joint proposal asking the court to determine that $500,000 is the appropriate amount of attorney's fee. Of that $500,000 figure, $350,000 is attributable to attorney's fees, $104,133 is attributable to expert witness fees and costs, and $45,867 is attributable to disbursements.

In the proposal, it is stated:

> The parties ... agree that $104,133 is a fair and reasonable amount for the services of ... [plaintiff's expert witnesses], that such services were necessary, and that WVUH [plaintiff] actually incurred such costs. However, defendants do not agree that

> WVUH is entitled to reimbursement of expert witness fees as a matter of law.

Joint fee proposal at 7. The issue of plaintiff's entitlement to expert witness fees has been fully briefed and it is addressed herein.

Discussion

While there is no Third Circuit Court of Appeals case directly on point, it has been understood, and it is not disputed, that under Section 1988, district courts may grant reasonable costs to successful civil rights litigants. E.g. Rank v. Balshy, 590 F. Supp. 787, 801 (M.D. Pa. 1984) citing Roberts v. S.S. Kyriakoula D. Lemos, 651 F.2d 201, 204-206 (1981). These costs may include expert fees "when the expert's testimony is indispensable to the determination of the case." Roberts, 651 F.2d at 206.

The parties have stipulated that plaintiff's experts were necessary. However, it is incumbent upon the court to note its reliance on the testimony of plaintiff's expert witnesses. Their testimony was essential to an understanding of the theories, issues, and facts crucial to the court's analysis and ultimate factual and legal determinations. Thus, assuming an award of expert fees is permitted by law, such an award is fully warranted in this case.

The defendants base their assertion that expert fees are no longer available under Section 1988 on the United States Supreme Court decision in Crawford Fitting Company v. J.T. Gibbons, Inc., 482 U.S. 437, 107 S. Ct. 2494 (1987). A victorious defendant in an employment discrimination action sought expert witness fees, as costs, in an amount in excess of the 28 U.S.C. Section 1921 limit of $30.00 per day. The Court held that district courts are bound by the $30.00 limit "absent contract or explicit authority to the contrary." Crawford, 482 U.S. at ____, 107 S. Ct. at 2496.

This language appears all-encompassing. However, three Justices specifically made reference to Crawford's non-applicability to Section 1988. Justice Blackmun's concurrence states in total:

> I join the Court's opinion and its judgment but upon the understanding that it does not reach the question whether, under 42 U.S.C. Section 1988, a district court may award fees for an expert witness. See post, at 2500, n. 1 (MARSHALL, J., dissenting).

Id. at ____, 107 S. Ct. at 2499. The footnote Justice Blackmun refers to states in pertinent part: "I do not understand today's decision to decide the question whether a district court may award expert witness fees under 42 U.S.C. Section 1988." Id. at _____, 107 S. Ct. at 2500. Justice Brennan joined Justice Marshall in his dissent.

Although the third circuit has not had occasion to address Crawford's applicability to Section 1988 awards, a number of district courts and two appeals courts have determined that Crawford's reach does not extend to Section 1988. E.g., Freeman v. Package Machinery Company No. 88-1130 (1st Cir. Nov. 22, 1988) (Westlaw); SapaNajen v. Gunter, 857 F.2d 463 (8th Cir. 1988); Black Grievance Committee v. Philadelphia Electric Co., 690 F. Supp. 1393 (E.D. Pa. 1988); Hillburn v. Commissioner, Connecticut Dept. of Income Maint., 683 F. Supp. 23 (D.Conn. 1987), aff'd mem., 847 F.2d 835 (2d Cir. 1988); United States v. Yonkers Board of Ed., 118 F.R.D. 326 (S.D.N.Y. 1987). Two fourth circuit courts, uncertain of Crawford's reach, have declined to rely on Crawford in denying expert witness fees. Harris v. Marsh, 679 F. Supp. 1204 (E.D.N.C. 1987) (because court was not certain whether Crawford reached the Section 1988 issue, in denying expert witness fees, it relied on a fourth circuit case, Wheeler v. Durham City Bd. of Ed., 585 F.2d 618 (4th Cir. 1978); Ecos, Inc. v. Brineger, 671 F. Supp. 381 (M.D.N.C. 1987) (court relied on Wheeler, 585 F.2d 618 in denying expert witness fees,

and characterizes Crawford merely as "persuasive authority" because it did not address Section 1988 directly); cf. Leroy v. City of Houston, 831 F.2d 576 (5th Cir. 1987) cert. denied ___ U.S. ___, 108 S. Ct. 1735 (1988) (noting Crawford did not specifically address the issue of fees under the Voting Rights Act, 42 U.S.C. Sections 1973-1974, the court construed Crawford's "general reasoning" as dispositive on the issue and denied any award for expert witness fees).

Conclusion

Despite a good effort by defendants to convince us otherwise, we find Crawford does not affect our circuit's law on the issue of expert witness fees under Section 1988. The fact-specific application of the Crawford decision, coupled with the emphatic statements of three Justices regarding the decision's inapplicability to Section 1988, make departing from accepted practice unattractive. Plaintiffs are entitled to expert witness fees. An appropriate order will issue.

SYLVIA H. RAMBO
United States District Judge

Dated: January 30, 1989